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Talking it Up! Project Report

‘Aboriginal voices in the formulation of health policy that works’
Acknowledgements

This report was made possible by contributions from many people. Firstly and most importantly, we thank the participants for taking part in the focus group discussions, attending community forums and providing feedback in later phases of consultation, without which this research would not have been possible. Participation was confidential, so we are not naming all of the participants here, but to everyone who took part we say: Thank you. Your ideas, stories and suggestions were sincerely appreciated and highly valued. We hope you like the final report.

The research was funded by the VicHealth Discovery grant program (Grant Number 2008-0077), and we thank them for funding research into Aboriginal health in Victoria.

The research was carried out by:

Co-investigators

Aunty Shirley Firebrace, community Elder and co-investigator. Aunty Shirley conceptualised the original idea for the project and facilitated the first round of community consultation, as well as providing editorial insight for the report.

Uncle Reg Blow, community Elder and co-investigator. Uncle Reg facilitated the second round of consultation and provided vital editorial input for the report.

Sarah Pollock, Wesley Mission Melbourne. Sarah is the lead investigator and submitted the grant application to VicHealth. Sarah provided the main analysis of the focus group and community elements of the project, and produced the majority of the material in the focus group chapter of the report. Sarah supervised the policy review at Wesley, and set up the criteria against which the policies were summarised.

Ann Taket, Deakin University. Ann is a co-investigator and provided research training for co-researchers. Ann developed the material for the introductory chapter and produced the stimulus questions for the second round of community consultation.

Acknowledgement of Country

We acknowledge and respect the Traditional Custodians of the Land, the Wurundjeri peoples of the Kulin nations on whose land this report was produced; and Elders past and present. As we share knowledge, learning and research within this report, we also pay respect to the knowledge embedded forever within the Aboriginal Custodianship of Country.
Sarah Barter-Godfrey, Deakin University. Sarah is a co-investigator and acted as liaison between the three parts of the project. Sarah provided research training for co-researchers and supervised the Deakin students. Sarah carried out the third stage of the policy analysis, including the ‘heat mapping’ and development of the policy chapter. Sarah developed material for the report and, together with Samantha Furneaux, provided the administrative support for the project.

Researchers (in alphabetical order)

Sandy Barber, community researcher. Sandy took part in the research training and facilitated focus groups discussions at the community forums.

Neil Bo Barney, community researcher. Neil took part in the research training and facilitated focus groups discussions at the community forums.

Troy Blow, community researcher. Troy took part in the research training and facilitated focus groups discussions at the community forums. Troy also assisted in the second round of community consultation and provided feedback on the interim report.

Andrea Gough, Deakin University student. Andrea carried out an initial scoping of health policy during her undergraduate health promotion placement, producing a report that informed the full policy analysis.

Peta Farquhar, Wesley Mission Melbourne. Peta identified, sourced and collated the policies used in the policy review. Peta produced the policy summaries for the first stage of the policy analysis and mapped the relationships between them in the second stage of the analysis, producing the materials presented in Appendix 4.

Samantha Furneaux, Deakin University. Samantha was the research assistant for the project and provided administrative support for the production of the report and discussion materials. Samantha carried out the literature review, and produced the diagrams used in the policy review to summarise the relationships between the policies, and the map to illustrate participants’ countries in the focus group study. Samantha completed the meta-synthesis analysis and diagrams presented in the introductory chapter.

Chris Halacas, Wesley Mission Melbourne. Chris took part in the research training and facilitated focus groups discussions at the community forums. Chris also assisted in the successful grant application.

Mary Hassall, Artist. Mary produced the artwork for the Talking it Up project. Mary also transcribed the group discussions, providing a careful record of the focus groups that was used to guide the analysis.
Danielle Thomson, Deakin University student. Danielle took part in the research training and assisted with the community forums.

**Artwork**

The artwork for Talking it Up was produced by Mary Hassall, and copyright remains with her. The artwork cannot be reproduced elsewhere without her permission.

**Artist statement:**
I am an Australian artist, in my 50s, born and brought up in various locations around Victoria, currently living and working in Darebin. My work reflects my interest in the way human beings relate to our landscapes, our backgrounds, both at home and away from home. I believe that in our creative endeavours, both as individuals and in groups, that we have the power to heal ourselves as people and to heal our relationships with all the Living Being of Earth.

**Enquiries, comments and feedback**

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ABN 81 098 317 125
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Where the project idea came from

The motivation for the Talking It Up project arose directly out of an earlier project that was being undertaken in collaboration between Wesley Mission Melbourne (Wesley), Aboriginal elders at Maya Healing Centre and Deakin University School of Health and Social Development (DU). The existing project, entitled ‘Healing Stories: experiences of the health system by Aboriginal and Torres Strait Islander people living in NE Melbourne’ set out to examine the experiences of Aboriginal and Torres Strait Islander people living in NE Melbourne when they accessed or attempted to access the health system. Like Talking It Up, this project was participatory in that the need for the project was identified by the Aboriginal elders through many years of working with Aboriginal and Torres Strait Islander people and their families, and in its design and execution, where control over data collection, data analysis, and reporting remained with Aboriginal and Torres Strait Islander people.

A strong and trusting relationship grew between the three parties. This was an important factor in the identification of need for the Talking It Up project described in this report. Aunty Shirley Firebrace (Women’s Program Co-ordinator at Maya at the time of the project) identified a lack of voice as a significant issue for the women she worked with. Many of these women experience a range of social deprivations that impact on their health and the health of their families. Compounding the situation in which they find themselves is the sense that they have no say in what is happening to them, in particular, no say in identifying the problems and issues that do the most damage to their own and their families’ health, and no say in coming up with strategies to address these problems. Likewise, Uncle Reg Blow (CEO of Maya at the time of the project) was working to assist men to work through the difficulties that many experienced by talking about their health and the things that impact on health, whereby having a voice could become a significant part of their healing.

As a result of many conversations within the frame of the Healing Stories project, the project partners formulated the design for the Talking It Up Project, and successfully submitted to VicHealth for a small discovery grant to fund the project.

Evidence of need for the project

Research evidence shows that Aboriginal and Torres Strait Islander people are over-represented in the populations experiencing chronic ill health, particularly in relation to heart disease, stroke and diabetes, as well as suffering poor dental care. Additionally, alcohol and drug abuse afflicts many Aboriginal and Torres Strait Islander people and families.
Research on health promotion suggests that strategies that work for non-Aboriginal and Torres Strait Islander populations do not work for Aboriginal and Torres Strait Islander people. Efficacy is also impacted by poverty. Finally, there is a general paucity of research on health and health-related issues amongst Aboriginal and Torres Strait Islander people and families living in metropolitan areas. Where research does exist, it tends to be at the level of population trends and generally does not seek Aboriginal and Torres Strait Islander people as actors in the research process and as agents of their own destiny through research projects with a participatory design (Jackson Pulver et al, 2007).

**Project design**

Initially, there were three separate strands to the work of the project: a series of forums involving group interviews/discussions with community members; a policy analysis that reviewed policies relating to Aboriginal health at federal and state level; and a literature review. Each of these is described in turn below. The results of these three separate strands of analysis were then brought together in a fourth strand to the work, a process involving community members to discuss and agree the overall recommendations contained in this report. This process is also described below.

Through this structure, the project employed a participatory methodology as the basis for individual and collective empowerment in relation to health outcomes. As mentioned above, the need for the project was identified by Aboriginal people, through their own processes of healing. The need was presented by appropriate figures within their communities, namely community elders. They invited other Aboriginal people to take part through their own communication channels, thus ensuring that responsibility for engagement in the project, and in formulating action for improvement, remained with Aboriginal people and their families. However, the project design also recognised that Aboriginal people exist within broader structural and policy constraints which impact on their ability to manage their own lives successfully or otherwise. Thus the project sought to combine indigenous and non-indigenous knowledge through bringing together the three strands of work in the way described.

A Community Reference Group guided the work of the project at all stages, endorsed the findings and drafted the recommendations. The two elders who had identified the need for the project formed the core of the group, and worked on the project from start to finish. At different times during the project, other community members joined the group to assist in its work, including training Aboriginal researchers, letting others know about the forums, discussing findings and drafting recommendations. The Aboriginal researchers were included in the group, attending meetings and providing input whenever they were able. It was important that the membership remained open and flexible, enabling people to take part in aspects that were important to them in a way that allowed them to attend to other commitments and events in their lives, as they arose. The group chose to work at Maya, as a safe space for themselves, and for the people who took part in the forums. The group
framed the partnership with the non-Aboriginal researchers in the project in terms of ‘reconciliation work’, Aboriginal and non-Aboriginal people working together to create change. This spirit was articulated by Aunty Shirley and Uncle Reg at the start of the project, and informed the design and development of everything that took place subsequently. In practical terms, the work involved a sharing of expertise and knowledge between the Community Reference Group and the non-Aboriginal researchers, regardless of the specific tasks that the various members of the broader ‘team’ undertook at any given stage of the project.

Research ethics clearance for the project was obtained through Deakin University Human Research Ethics Committee, as a modification to the existing Healing Stories project (EC 228-227).

**Project strand 1: Participant forums**

The project included four participant forums which were held to identify and discuss issues impacting on health and strategies to address problems. On the advice of the Community Reference Group for the project, the forums were structured to include opportunities for women’s business, men’s business and family business. To this end, four groups were held, two men-only (7 and 12 participants), one women-only (18 participants) and a mixed group (30 participants: all participants in the mixed group had attended one men’s/women’s group). In all, 35 people took part in the groups. Participants were recruited through a range of existing channels within the community, a process controlled and undertaken by the Community Reference Group. Forums were held at Maya, a space which Aboriginal participants were familiar with and frequently used for other purposes.

Participation was self-selected, that is people chose to identify themselves as Aboriginal and over 18, and chose whether or not they wanted to take part. The standard pro-forma for consent asks participants to identify themselves by name and where they are “of”; for these participants the “being of” element was broadly responded to as which land or mob with which they identified. There is great diversity within a geographically local urban or metro Aboriginal community, diversity of culture and language, and a range of countries with which people are affiliated. It is important not to assume that everyone is from the land on which the research is carried out, or that people are only affiliated with one land or mob. The sample self-identified as being from countries across Victoria, New South Wales, Queensland and Western Australia – a diversity that would not be adequately captured by traditional items asking people where they live now or where they were born. Seven out of the 22 people who responded to “being of”, identified two countries, both of these are included in the summary of where the participants are “of”. As these are fairly small numbers, frequencies have been grouped into 1-3, 4-6 or 7 and more to protect the privacy of the participants. Figure 1.1 presents a list of the countries that participants identified themselves as “being of”, including spelling variations.
Participants were encouraged to identify the individual and social issues impacting on their health and ill-health, and had a large degree of control over the direction that the discussion took within this broad framework. Each of the forums was facilitated by Aboriginal researchers drawn from the community and trained within the scope of the project. They were assisted on the day of each forum by the non-Aboriginal researchers, who provided support in any way that the Aboriginal researchers required. Each forum was recorded and transcribed for analysis; during transcription, any statements that potentially identified the speaker were de-identified. The data was then coded, and reconstituted under different categories representing the emerging themes. Following this, the data was re-analysed to consider the relationship between the various categories and themes.

The transcripts revealed that participants both described and offered explanations for the situations they found themselves in. This was a complex, interlinked articulation of their social situation which forms the basis for an emergent theory of urban Aboriginal health from the perspective of Aboriginal people living in the metropolitan area.

A summary of issues and strategies from the combined forums was made available to all participants that had provided postal contact details, and were discussed at a second community forum which was attended by interested participants. The data from these
forums formed the basis of the community evidence base, presented within the next chapter of this report.

**Project strand 2: Literature review**

The research team conducted a literature review which focused on the policy implications of existing research relating to the health of, and health promotion for, Aboriginal and Torres Strait Islander people in metropolitan communities. This review sought focus on the part of the literature that can be applied to Aboriginal people living in Victoria, a predominantly urban or metropolitan population, geographically embedded within multi-cultural cities and towns (ABS 2007). The review takes a human-rights based position, which emphasises the importance of social justice, and an essential need for the autonomy of, and engagement with, Aboriginal people in the governance and improvement of their/our communities. Where possible, we sought to take a holistic approach to Aboriginal health policy; in terms of both a holistic notion of health and a holistic, or intersectoral, notion of policy and health governance.

Three types of research literature were sought. Firstly, evaluations of specific policies identified in the policy review section of the Talking It Up project; secondly, primary research around health and health promotion from urban Aboriginal communities that had policy implications; and thirdly, secondary research or commentaries that critiqued the evidence base and/or policy outcomes for Aboriginal health. A search for empirical research around specific Aboriginal health policy, as well as current research around health and health promotion for urban Aboriginal communities was conducted using all databases available through EbscoHost, including Academic Search Premier, CINAHL, Global Health and Medline. Search terms were: Aborigin* or Indigenous AND health AND Australia* (where “*” is a truncation term that allows for multiple variations of the root word, for example Australia* would identify Australia and Australian and Australians). A sub-set of the search was limited to urban or metro areas, to filter out research only conducted within very remote communities. The publication date was limited to 2000 onwards, in line with the earliest year of introduction of current Aboriginal health policy, as identified in the policy review. Grey literature was searched for using Google Scholar, and the titles of existing policies (identified in the policy review) were used as search terms through the main Google search engine, to identify other commentaries or evaluations available through grey or other non-peer reviewed sources.

Articles identified by the search strategy were read and thematically analysed, identifying key themes in the literature. These are reported in the chapter on the literature review later in this report, and summarised in Figure 2.1.
Project strand 3: Health policy

This part of the project sought to review current Aboriginal health policy, applicable to Victoria. Health policies are the decisions, announcements and documents that guide and govern health delivery. These include health-related frameworks and strategies, which give direction to health service providers and regulators. Policies articulate how health should be delivered, regulated and accounted for and it is important to consider the policy environment as this is one of the most important points of communication and negotiation between those in control of health delivery, those responsible for delivering health, and their clients. For the purposes of the policy review, only published documents that come from health related departments at the Federal or Victorian state level are included. Policies that do not extend beyond announcements or decision-making, i.e. are not implemented or disseminated sufficiently for others in the health sector to follow, are not included. Therefore this review seeks to analyse the policy documents that form the shared policy environment for the health sector, its workers and its clients.

The policy review was a detailed process of collecting and documenting the policies that govern and guide Aboriginal health in Victoria. This includes national policies and frameworks, as well as those specifically from Victoria. The first part of the process was to identify the policies that govern Aboriginal health. It was not possible to find a single-site summary of health policies relevant to Aboriginal health, so policies were collated from a range of sources. These included Australian Policy Online (www.apo.org.au); Victorian Government Online (www.vic.gov.au); Department of Health and Aging (www.health.gov.au); and Department of Families, Housing, Community Services and Indigenous Affairs (www.fahcsia.gov.au). Policies were included if they were: current, specified a remit for Indigenous or Aboriginal health; existed in a policy document as a policy, framework, strategy or guidelines. Policies were excluded if they were only applicable to states or territories outside of Victoria, or if they did not have a remit or a specific and substantial policy for Aboriginal or Indigenous health. In total, 15 Federal/national policies and 9 Victorian/state policies were identified. An additional policy, the National Framework for Aboriginal Health 1989, was initially excluded because it was not current implemented, although it became useful in later stages of analysis as it remains influential in the policy environment. A complete list of the policies included in the review is presented at the beginning of the chapter on health policy.

The analysis was carried out in three stages. The first stage was an initial analysis, summarising the policies, frameworks and strategies against a criteria that aimed to identify key aspects. The criteria covered the extent to which the policy governed Aboriginal health (which level of government, its jurisdiction and who it applies to, its longevity and for how long it applies, its level of impact as guiding or obligatory); its aims and rationale (what it sets out as its objectives and why); what outcomes it seeks and whether these will be monitored; how it proposes to implement its aims; how much money has been allocated to achieving its aims; and additional key points about what actions will be done and by whom. The full criteria are presented in Figure 3.8. The second stage of the analysis was to
identify the relationships between the policies. Sometimes this was very clear, where policy
documents state that they are guided by or build upon the principles of existing frameworks;
or where later strategies are the implementation plans of earlier frameworks. Sometimes
the relationship was less clear. These relationships were mapped and a full, but somewhat
complicated, database was produced which located each of the policies presented here
and their stated inter-relationships. To simplify the presentation of this analysis, each policy
has its own relationships presented in a diagram at the start of its policy sub-section.

The third stage of the policy analysis was to compare the policies against each other, along
dimensions of interest identified by the literature review and community forums. These
dimensions included: the extent to which Aboriginal people and communities had been
involved or consulted in the policy process; the extent to which policies indicated an
integrated policy environment; and the extent to which policies were informed or guided by
principles of good practice for Aboriginal health (specifically the National Strategic
Framework for Aboriginal and Torres Strait Islander Health 2003-2013). This analysis used
a variation of the ‘heat mapping’ technique, where coding is represented visually by using a
gradient of shading; deeper shading represents a greater extent. Heat mapping has the
advantage of using categorical data in a way that is indicative of a gradient without needing
to use numerical data, and therefore supports comparisons across a variety of data
sources. The fourth stage was the period of community consultation, where co-investigators
and community members contributed to revisions and interpretation of the policy analysis.
Findings from all stages of analysis are presented later in this report, in the health policy
chapter.

Project strand 4: Formulating project recommendations

Following the completion of each of the three strands described above, the researchers
developed a summary report which contained key findings from each of the strands. They
discussed the emerging findings with the two elders in the Community Reference Group,
and developed a set of questions which could inform the development of recommendations
for the project. A second round of community consultation, facilitated by the community
Elders, was arranged for participants to discuss the interim report and to draft
recommendations. It was intended that all original participants would be invited, and
although it was not possible to make contact with them all prior to the session, everyone
who had provided a postal address at the first participant forums was invited to attend. Five
people attended the session, and worked on the interim report and recommendations.
Subsequently, as further contact was made, all participants who had provided a postal
address were sent a copy of the summary report and offered a variety of ways in which to
provide feedback to the research team. All feedback received prior to October 23rd 2009
was incorporated in to this final project report.
Project findings

The policy review identified that health policies tend to be focused on health outcomes (related to specific disease/s) and rarely demonstrated holism in their conceptualisation or measurement of health and wellbeing. There is varied and sporadic explicit connection between different policies and strategies, and the interrelationship between the different strategies is confusing.

The project identified tensions around the best ways to approach policy work with indigenous communities:

- tension between statistical equality and cultural diversity, where the goal of normalising Aboriginal people fails to recognise or celebrate cultural differences in health patterning within the Aboriginal population and between Aboriginal and non-Aboriginal populations;
- tension between the need for Aboriginal-specific health policy and the realities of integrated, urban communities, and the way in which Aboriginal health policy tends to segregate Aboriginal from non-Aboriginal people and broadly fails to recognise the role of non-indigenous Australians in the improvement and delivery of Aboriginal health, and
- tensions across the policy process, with calls for greater consultation and engagement with the community at all phases of the planning, policy-making, implementation and evaluation cycle. The focus on health outcomes fails to incorporate a historical perspective, which would allow for greater recognition of and emphasis on historical and structural determinants of health. Gaps between policy intention and implementation also exist, and require greater engagement with the broader social and structural context within which Aboriginal health exists.

The policy analysis undertaken as part of the project reveals that Aboriginal health policy is often formulated without the incorporation of indigenous knowledge systems, which would situate policy in a culturally appropriate context. Specifically, the project finds that the development of policy which is informed by the best knowledge from both indigenous and non-indigenous knowledge systems is an emerging area for further study and policy development work. This raises particular issues for Aboriginal people living in urban areas, where the notion of ‘community’ is marked by diversity of cultures and knowledges. One of the outcomes of this situation for urban Aboriginal people is inequitable access to services and supports, where some people are shunned by the Aboriginal Controlled part of the system because of their particular associations with mob and country.

The three chapters of the report present different types evidence for Aboriginal health, as part of a coherent whole which understands Aboriginal health from a community, research and policy perspective. Each chapter presents a different set of arguments to explain Aboriginal health and healing. While there are no active contradictions between the three chapters, aspects of health and healing are presented with different emphasis, in different
lexicons and to differing extents. Within each chapter there are themes identified in the material discussed (see thematic analysis of the participant forums; thematic summary of the literature; and the themes presented in the policy review). Strikingly, the themes raised by the participants’ voices were strongly endorsed by the evidence in the literature and the ‘gold standard’ of Aboriginal health policy, the nine principles of the National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013 (see Appendix 5). To explore this further, a brief meta-synthesis was carried out at the end of the project to identify the common themes that emerged from the project as a whole. The meta-synthesis involved grouping together key themes from the three strands of the project, to identify common ideas or ‘meta’ themes. Seven meta-themes were identified: holism; identity; cultural respect; collaboration; power and control; health sector and services; and reconciliation. These are displayed in the following diagrams.

Key:
Orange themes come from the participant data
Blue themes come from the literature review
Purple themes come from the nine principles of the National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013
Cultural Respect

The build up of past and present racism

Cultural Respect

Equality and difference

Culturally appropriate policy
Collaboration

- Dialogue and reparation
- Working together
- Collaboration
- Consultation & partnerships
- Engagement with Aboriginal communities
Reconciliation

The need for a new story to be accepted

Legacy of colonisation

Effects of the past in the present

Context: historical, social and cultural

Reconciliation and history
Project recommendations

These recommendations were drafted initially with the researchers and Aboriginal elders working together. They were then considered in detail and revised through the community feedback process. As such, these are the recommendations of the Aboriginal people who took part in the project, on the basis of the shared understanding of their health and healing that they developed as a result of taking part in the project.

Health policy

1. A revision of Victorian health policy should be undertaken so that it integrates the past and the present, through explicitly addressing the effects of dispossession and discrimination, and providing access to the pre-requisites for health (housing, education, employment etc), as well as focusing on disease reduction.

2. Victorian health policy should explicitly call for the incorporation of indigenous knowledge systems into service delivery, enabling the funding of forms of non-clinical healing services which focus on the development of consumer and community autonomy for health.

3. Policy should be accompanied by two sets of outcomes measures: the first relating to the impact of dispossession in spiritual, emotional and physical domains; and the second relating to increased longevity and disease reduction.

4. The voices of Aboriginal service users (as opposed to the voices of Aboriginal organisations) in the formulation of health policy should build on the good practice that exists for some policies at national level. Implementation should be strengthened by ensuring that Government health plans are explicit about their processes for Aboriginal service user participation.

5. Aboriginal participation in policy formulation should be strengthened by a program of community education aimed at Aboriginal service users, and through access to culturally appropriate supports for participation (e.g. family-member advocate system to aid network participation).

Expanded service delivery

6. New forms of service should be developed and funded which enable Aboriginal people to come together to share their experiences of past abuse within a culturally appropriate framework for spiritual healing. These services
should be supported by standards and protocols, explicitly based on indigenous knowledge, which can apply within and across agencies, to ensure that spiritual healing is a component of all health service delivery.

7. Service delivery should focus on integrated models of provision which link services in different life domains, including services which are focused on building individual and community capacity building (e.g. literacy, numeracy and vocational and general education).

8. Data collection systems should be developed and implemented that enable the state bureaucracy to accurately determine the coverage of health services in relation to the Aboriginal population. Data collection needs to be located within an independent, centrally controlled body which comprises Aboriginal and non-Aboriginal representation, and implemented across all health service provision, including the Aboriginal Controlled and mainstream sectors.

9. Aboriginal people should have access to a service which protects their rights as consumers, which builds on existing structures within Consumer Affairs Victoria, by actively using Aboriginal consumer rights workers to work within ‘grass roots’ organisations and distribute information on rights in and across all relevant health service providers in Victoria.

10. Aboriginal people working in Aboriginal Controlled Health Organisations (ACHOs) should have access to funded, professional supervision, as well as ongoing professional development, to ensure that they are supported in their work and to build capacity within the ACHO sector. Professional development should reflect cultural protocols and rituals.

11. The implementation of the newly developed Cultural Competency Framework (in the Child and Family Services sector) should be extended and linked to service delivery in all policy areas that impact on the lives of Aboriginal people, including existing and new policy.

Advocacy partnerships for systemic change

12. VicHealth, supported by Consumer Affairs Victoria and Aboriginal Affairs Victoria, should lead the way in brokering conversations about the ‘elephant in the room’ (the reported ‘shunning’ of some people by some services within the Aboriginal Controlled Health sector, resulting in inequitable access to services and supports and/or poor treatment). The conversation should be framed within the business of consumer rights, and relate to access and choice for Aboriginal consumers.
13. VicHealth, in collaboration with Deakin University (DU), should advocate for the inclusion of Aboriginal health within health and allied health courses taught in all Victorian education institutions. The School of Health and Social Development will advocate within DU and other universities to start this process.

14. Wesley Mission Melbourne (Wesley) will review its own service delivery and implement measures that make services more accessible for Aboriginal consumers. Wesley will share its experiences with other community sector organisations, and advocate for organisational and systemic change which improves access for Aboriginal consumers to mainstream services.

15. Community education/campaign (like the recent Reconciliation Australia campaign to tackle discrimination) around the racism that Aboriginal people historically and currently experience should be provided, and funding sought by VicHealth and the Talking It Up partnership from a philanthropic source to undertake this.

New knowledge and understanding (further research)

16. More work needs to be done to understand what a successful life looks like for Aboriginal people, situated within an understanding that talking about stories of success is an important part of healing, and including stories from the individual, family and community levels, as well as those that focus on what Aboriginal and non-Aboriginal people have done together.

17. More work needs to be done to identify and understand what Aboriginal people need to feel safe when they are living away from their country, with the aim of creating new ways of feeling safe that are community-generated and community-supported, rather than through a reliance on Government.
How to read the report

The report comprises three sections:
- The evidence base for Aboriginal health that was developed from the community forums;
- A review of the literature on Aboriginal health; and
- A review of relevant policy.

Each of these can be read as a stand-alone summary of community views, key arguments from existing literature and an overview of the policy environment. However, when put together, they form a developing evidence base of good practice and directions for reforms for effective and healthy Aboriginal health policy.
Chapter 1: COMMUNITY GROUP DISCUSSIONS

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Introduction

The first and most important strand of the Talking it Up project was a focus group study with participants from the local Aboriginal community. The group discussions, held at community forums, sought to ask people about the things that influence their health and their access to healing to begin to explore the policy needs of Aboriginal health in Victoria. Discussions explored the individual and social issues impacting on health and ill-health, across issues which impact on chronic ill-health and those which bring about positive health outcomes.

Research evidence (discussed further in the literature review chapter) shows that Aboriginal and Torres Strait Islander people are over-represented in the populations experiencing chronic ill health. Health promotion strategies that work for non-Indigenous populations are not necessarily effective for Aboriginal and Torres Strait Islander people, and efficacy of strategies and policies is also impacted by poverty. Health policies tend to create ‘additional’ strategies that supplement mainstream policy (explored further in the health policy chapter), and research tends to focus on rural or remote Aboriginal communities rather than metropolitan areas (although population patterns suggest that the majority of the Aboriginal population resides in urban/metro areas). Where research does exist, it tends to be at the level of population trends and generally does not seek Aboriginal and Torres Strait Islander people as actors in the research process and as agents of their own destiny through research projects with a participatory design (Jackson Pulver et al, 2007). This study was therefore designed to engage with local community members, drawing participants from urban, metro communities, and with discussions facilitated by community members as trained co-researchers.

Method

Data was collected via a series of community forums with Aboriginal people, aged over eighteen years, and currently living in metropolitan Melbourne. The forums were advertised through the distribution of a flyer and by word of mouth through the ‘Koori grapevine’. Members of the Community Reference Group in particular used their networks to let other services know about the forums. Participants self-selected to be part of the project, and no attempt was made at specific representation.
On the advice of the Community Reference Group for the project, the forums were structured to include opportunities for women’s business, men’s business and family business. To this end, four groups were held, two men-only (7 and 12 participants), one women-only (18 participants) and a mixed group (30 participants: all participants in the mixed group had attended one men’s/women’s group). In all, 35 people took part in the groups. Participants were recruited through a range of existing channels within the community, a process controlled and undertaken by the Community Reference Group. Forums were held at Maya, a space which Aboriginal participants were familiar with and frequently used for other purposes.

Participation was self-selected, that is people chose to identify themselves as Aboriginal and over 18, and chose whether or not they wanted to take part. The standard pro-forma for consent asks participants to identify themselves by name and where they are “of”; for these participants the “being of” element was broadly responded to as which land or mob with which they identified. There is great diversity within a geographically local urban or metro Aboriginal community, diversity of culture and language, and a range of countries with which people are affiliated. It is important not to assume that everyone is from the land on which the research is carried out, or that people are only affiliated with one country. The sample self-identified as being from countries across Victoria, New South Wales, Queensland and Western Australia – a diversity that would not be adequately captured by traditional items asking people where they live now or where they were born. Seven out of the 22 people who responded to “being of”, identified two countries, and both of these are included in the representations, below, of where the participants are “of”. As these are fairly small numbers, frequencies have been pooled into 1-3, 4-6 or 7 and more.

Figure 1.1 presents the list of countries that participants identified themselves as “being of”, including spelling variations. To represent the geographic diversity of the participants’ identities (all of whom presently reside in Victoria), the countries were located using a detailed map of Aboriginal and Torres Strait Islander lands (available online at: http://yolngu.net/yolngu.html). One of the countries listed in Figure 1.1 (Murri) was not included in the our geographic map as it was possibly associated with more than one region. The map of participants’ countries is presented in Figure 1.2.
Figure 1.1: Participants’ countries

<table>
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<th>1-3 participants</th>
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<tr>
<td>Bundjalung</td>
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<tr>
<td>Dainggatti</td>
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<tr>
<td>Gumbainggir</td>
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<tr>
<td>Guna (Gunai)</td>
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<tr>
<td>Gunditjmara</td>
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<tr>
<td>Murray (Murri)</td>
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<tr>
<td>Ngarrindjeri</td>
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<tr>
<td>Noongar</td>
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<tr>
<td>Wiiman</td>
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<tr>
<td>Tjapwurung (Djabjawurung)</td>
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<tr>
<td>Waka Waka</td>
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<td>Yagara (Yuggera)</td>
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<th>4-6 participants</th>
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<tr>
<td>Wamba Wamba (Wemba Wemba)</td>
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<table>
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<th>7 or more participants</th>
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<tr>
<td>Yorta Yorta</td>
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Figure 1.2: Map of Participants’ Countries
The project researchers provided training in group facilitation to Aboriginal community members. The training included the development of the schedule (or questions) that the groups were to consider – this process was undertaken by the Aboriginal facilitators. Each group was convened and lead by one of these facilitators, with the non-Aboriginal researchers present on the day of each forum to assist their Aboriginal colleagues in any way that was required. Formal consent was obtained from all participants by the non-Aboriginal researchers, prior to the commencement of the group session.

Each forum was audio recorded and transcribed, including de-identifying any potentially identifiable statements. The data was then coded, and reconstituted under different categories representing the emerging themes. Following this, the data was re-analysed to consider the relationship between the various categories and themes. A summary of issues and strategies from the combined forums was made available to all participants that had provided postal contact details, and were discussed at a second community forum which was attended by interested participants. Participants were contacted by post if they had provided a postal address and through word of mouth, facilitated by the Community Reference Group. Details of the project materials are available in the appendices, including: a poster used at Maya to advertise one of the community forums (Appendix 1); the invitation to attend the second consultation (Appendix 2); and the summary report circulated to participants at the second consultation and subsequently by post to those who had provided a postal address (Appendix 3).

The transcripts revealed that participants both described and offered explanations for the situations they found themselves in. This was a complex, interlinked articulation of their social situation which offers an exploratory at theorizing urban Aboriginal health from a grounded perspective.

Findings

Emergent themes have been arranged into four groups, which are discussed in turn:

1. Effects of the past in the present
2. Identity and voice
3. Service quality and gaps in provision
4. Promoting healing
5. Warriors and tiddas

The fifth theme winds its way throughout the other four themes, but has been selected out for separate comment. The separate experiences of men and women, their interpretation and the meaning each gender group placed on them are worthy
of comment, and in keeping with the ‘men’s business’ and ‘women’s business’
structure of the forums.

This section of the report concludes with a consideration of the relationships
between these themes, which forms the basis for an emergent theory of urban
Aboriginal health from the perspective of Aboriginal people living in the metropolitan
area.

1. Effects of the past in the present

a) Sickness is everywhere

*There’s so much hopelessness ... what’s the use
People are sick with worry*

Sickness is everywhere: individuals, families, and communities are all sick. It is a
hard way to live, and hard to know how to heal oneself and others. Alcohol, drug
addiction and violence are responses to the frustration and hopelessness. This
perpetuates, or creates, an intergenerational aspect, which is mutually reinforced by
current policies, e.g. child protection.

b) The family is the site for sickness and healing

*We need to focus on healing and looking after each other, so you don’t get bitter about how dysfunctional things are
Men and women are both unwell – why aren’t we helping each other instead of fighting all the time?*

The family is the site for sickness, and also contains the possibility for healing. For
this to happen, strategies and supports for people to identify with, and connect to,
culture, land (home) and community are needed.

c) Lack of respect and its connection to ill health

*How do I find ways of feeling good about myself?
Whitefellas always looking down their nose at us*

Lack of respect, experienced personally and communally, within communities, within
families, and between black and white Australians, is strongly connected to ill health
and an inability to heal.
d) Dispossession is linked to ill health

Blackfellas need their land
The dreamtime was love, peace and justice...this is gone for blackfellas

The effect of dispossession, and its linkage to ill health, needs to be understood at personal, infrastructural, and legal levels. At the personal level, the loss of land (and therefore culture) impact on self-esteem and mental health, and is linked to poor choices which perpetuate dysfunctional life circumstances. At the infrastructural level, a lack of housing and support services (in particular, services for people in and leaving jail, and for women fleeing family violence) contribute to an ongoing experience characterised by rootlessness, instability and transience. At the legal level, the lack of real land rights, the failure of native title in Victoria, and difficulties with proving aboriginal identity mean that basic structures for well-being are lacking.

e) Living in ‘no man’s land’ affects health

If you’re born in the city, how can you ever connect to land, smell the gum trees? I get condemned if I go to someone else’s country...

Dispossession has left Aboriginal people trapped in a kind of no man's land, where, to function in the mainstream economy, they often have to leave their country, but then find themselves in somebody else’s country without proper protocols for establishing themselves. Finding a 'home ground' in a strange land is a key part of being able to flourish in contemporary society.

f) The build up of past and present racism

I grew up in a time when you needed a ticket to go off the mission land
For me as a worker to be treated like that in a public hospital, I was disgusted

Experiences of racism carry forward from the past, and exist independently in the present, with a compounding affect. The impact of growing up with constant, overt discrimination has a massive impact on individual identity and self-esteem, leaving people feeling that they would "never be good enough", only ever be "second-place", having "no place or role". Contemporary and continued experiences of racism, especially those felt within the service system, leave people feeling degraded and worthless. This has an impact on people's ongoing engagement with services.
2. Identity and voice

a) Loss of cultural identity and role

You had your place in the law and in the family

In the past, culture provided people with a role, place and social system that allowed them to flourish as families and communities, including processes for dealing with events that disrupted the social fabric. For many people who now live in an urban area, this has disappeared within a generation. For the men (for whom this appeared to be particular important), this was portrayed through nostalgia for an idyllic past, which they set against descriptions of a dysfunctional present.

b) Feeling invisible

We are treated like children in our own country
There’s nobody out there to listen to us, because everyone knows everything

Aboriginal people feel invisible in their own country. This has a number of dimensions. Firstly, they feel that what they have to offer (e.g. in regards to sustainable treatment of water and land) is ignored. Secondly, despite the perpetuation of age-old problems, they have no voice in policy which affects the health and well-being, despite having valuable knowledge in relation to the problems and their solutions. Finally, they are at a loss to understand what they need to do to get listened to.

c) Loss of voice is about loss of respect, and vice versa

Health is a big industry ... aboriginal people are perfect clients
And then, as you got older, we started thinking about taking responsibility and who you wanted to be, making a spear, a boomerang

Having a voice and being respected are connected. They talk about the ways in which they have been problematised and commodified, as "dysfunctional clients", a disempowered and disempowering position in which other ‘experts’ come and ‘know about’ and ‘do things to’ them. There is the sense that they risk becoming identified with a pathology e.g. sexual assault, drug and alcohol, violence, or criminality. Counter to this is a view of themselves as guardians of the land and holders of knowledge, both in relation to the environment, and in relation to healing their own communities.
d) The invisibility of urban Aboriginal people

Tourists get told we’re not blackfellas…well, what are we?
We got people out there that say they’re black, but they’re not black…they’re taking the system for a ride

As urban Aboriginal people, perhaps with pale skins, they feel particularly invisible. This is reflected in the repeated difficulties of proving Aboriginality and in the feelings of rejection that come with not being counted.

e) The need for a new story to be accepted

I could kill everybody all of the time – it’s just not healthy
People didn’t want to hear the bad stories, just the nice feeling stuff – it’s important to hear the impact the past has had on people

A return to visibility would involve recognition of past wrongs and an acknowledgement of history on their terms, as well as effective mechanisms for representation. Men associate unfair treatment within the legal system, both historically and currently, with powerlessness and frustration. They feel let down by the legal system, and not sure where how to get redress. Combined with the overt racism that they have experienced, this is a strong feature in their description of their own poor health, violent reactions to their invisibility and recourse to drugs and alcohol.

For these men, the value of the social circle in healing (see section 4a) lies with its capacity to function as a safe place in which to share unjust experiences and the anger and hurt that these give rise to. As such, talking and sharing is an alternative to more destructive and alienating courses of action.

3. Service quality and gaps in provision

a) Service system problems

What I really need is a carer where I live, someone to keep an eye on me and speak on my behalf. Coz I dunno what to say half the time on my behalf. I leave home to go to the doctor’s surgery. By the time I get to the doctor’s surgery I’m in another world, know what I mean?
More [healing] circles…I believe that everyone has a voice and that through times gone by our voice has been…stopped. These circles are imperative for us to get stronger and listen to and hear each others' stories

Women, in particular, focused on problems within the service system, and what is needed to fix it. There are two key areas for service development. The first of these relate to social services, in particular, family violence and housing, and services for people in and coming out of prison. Integrated services, particularly those which have a mental health dimension, are important. It is important that service design and staffing are capable of responding to the complexity and multi-dimensionality of experiences and issues that people have. The second area relates to cultural services, those which build understanding and recognition of aboriginal culture, within aboriginal and mainstream organisations, as well as services direct to families. These might include support for families to take trips to country with the purpose of building culture with their children, and support for travel to funerals.

b) The need for service models which draw on indigenous knowledge systems

We know what the problems are, because we’ve experienced them – we know what needs to be changed to make things better
Women need to talk about it, what they’ve been through – not bear it alone

There needs to be a focus on preventative services, including child care and women’s programs, and programs to teach people how to stay out of prison. Participants in the women’s group talked about the need for service models which draw on communities’ knowledge (for instance, strengths-based approaches). The women also questioned the competencies required to work with people who had experienced complex and entrenched disadvantage. They recognised the precarious position of relying on workers from the communities in question, with their expert and first hand knowledge of the problems that service users face, and the need to ensure that those same workers were supported in their own healing journeys.

c) Inequitable access to services: the ‘elephant in the room’

An industry has been made out of our misery
There is a lot of discrimination…even in our own orgs…they can get a bit toffee, not compassionate enough

The major issue in relation to service provision and quality, however, concerned divisions within the Aboriginal population in Victoria, where some people found themselves unable to access particular services, despite being eligible. In the words
of one participant, ‘there is a division in the community between the rich black bureaucrats and the little group that are suffering down there’. This phenomenon is closely related to nepotism in the non-Aboriginal community. One female elder described this as the act of ‘shunning’, where one individual or family will ‘shun’ or turn their backs on another, leaving them out of the circle through which Aboriginal business, including healing, can be done. Examples of shunning included discrimination towards some individuals and families, depending on who is on the board or staff of the service providing organisation. It covers difficulties with proving aboriginality. And it raises questions about where do people go when they are turned away from these organisations. The discrimination from within the community is felt all the more painfully, and whilst it is clear that it needs to stop, is not clear how this is going to happen. Because of the difficulties of discussing this experience with actors in the service systems, it can be regarded as ‘the elephant in the room’ of Aboriginal services.

Although the participants talked freely about this issue in the safety of the spaces that the project provided, there is a great deal of reluctance to talk more publically. Moreover, the non-Aboriginal researchers noted that it is also difficult to find a way to talk constructively about it within the broader health and community services system. In particular, they contemplated the outcomes of dismissing it as ‘Aboriginal politics’, and considered that this was a form of abrogation of responsibility of the part of the mainstream system.

4. Promoting healing

a) Talking and listening as acts of healing

Healing is about having someone to talk to, so that you can feel you’re important to someone
Women need to stick together and remain proud of their families, despite the violence and death

Healing and well-being were not expressed in relation to curing disease, but in terms of having a voice to talk to each other, the healing experience of being listened to, and feeling cared for. Talking is central to the healing process. Talk and sharing experience are seen as acts of healing, active experiences that are constitutive and productive. Talk is the carrier and shaper of culture, it is a means of showing care for self and others, and thus a means of healing individually and communally.
b) The importance of being in control

*We’d like people to look at Aboriginal systems of living and environment, and learn from that*

The importance of spiritual continuity – even if we are physically changed

A second aspect of healing was about feeling in control of their own lives, through the provision of services in which they had a say, and the means of being represented in decision-making at all levels of governance.

c) Dialogue and reparation

*We have a strong knowledge base here*

*We could be included and respected for our input into debates*

Dialogue is seen to be important as a means of reparation and progress, and is the means of bringing together talk and control. Dialogue is needed at a range of levels: interpersonal, family and community, between different aboriginal communities and between aboriginal and non-aboriginal communities. Dialogue needs to occur within a recognised set of structures, which would include a treaty and a system of representation linked into broader governance arrangements. In particular, women expressed the desire for a voice of their own, recognising their strength in numbers, and expressing their desire for control of their own resources.

5. Warriors and tiddas

Whilst the themes were common to both men and women, there were differences in their expression, emphasis and interpretation. The men, who referred to themselves as ‘warriors’, showed greater concern with the loss of their traditional role as protector of family and land, and that the impact of this cultural dispossession had on their health and well-being. The women called themselves ‘tiddas’ (sisters), and talked largely about what was needed to support and protect their families.

This appears to reflect a shift in the protector/guardian role from men to women, a cultural disruption which is damaging for both genders. The men were able to offer an analysis that centred on their double dispossession, first by the failure of modern urban society to ‘reconstruct’ a role for them, and secondly by the loss of their role to their women. The women didn’t talk in terms of their liberation from their traditional role, but about the heavy burden of this shift, which required them to care for their men as well as their families, in order to carry their cultural traditions forward for future generations.
This leads to the need for spaces in which Aboriginal men can talk to and share their experiences with each other, and likewise, spaces where Aboriginal women can talk to each other. The women, in particular, articulated the need for a representational voice to ensure that women’s experiences and issues are included in broader governance structures. The women talked about the link between family violence and loss of voice, which made it ‘hard to find my way out’. Women did not turn their backs on the men who were violent, but talked about their need to have separate, safe spaces in which they could share their experiences and regain their self-respect and pride in their culture and who they are.

**Relationship between the themes**

The diagram in Figure 1.3, on the next page, was developed and refined in conjunction with the Aboriginal co-researchers to show the inter-relationships between the emerging themes. Themes have been grouped into three main strands: factors impacting on health and well-being; interventions that promote healing; and, collaborative advocacy for reconciliation and healing.

In the first strand (factors that influence health and well-being) the vertical arrows show how the factors that influence health and well-being are causative and cumulative, resulting in widespread, even ubiquitous, sickness. In the second and third strands, the vertical arrows show how the different forms of intervention (including advocacy) build on each other to promote good health.

Within each strand, thematic elements have been grouped together to show strong relationships between those themes. Horizontal arrows indicate relationships across the three strands. Thus, themes relating to dispossession and loss are grouped in the first strand, are best addressed by interventions to tackle racism and discrimination in the second strand, and require health policy which tackles the effects of the past and the present, shown in the third strand.

The interventions to promote healing are related to the various factors impacting on health and well-being, and combine to suggest an integrated approach to health and healing for Aboriginal people which addresses the concrete and symbolic aspects of their lives.

Although the exploratory theory presented in this diagram has come from the unique experiences of the people who have participated in this project, it is endorsed in the boarder literature relating to Aboriginal health. This is explored in detail in the next section of this report.
Figure 1.3: Thematic Diagram from Focus Groups

Factors influencing health and well-being

- Dispossession from land and culture
- Loss of role and identity, and loss of respect of self and from others
- Loss of voice, and deep alienation
- Poor quality/adequate services, and/or ineffective service models
- Sick people, sick families, sick communities

Interventions to promote health

- Interventions to address racism & discrimination
- Integrated, holistic services, drawing on indigenous knowledge
- New forms of healing services for cultural and spiritual health

Collaborative advocacy for reconciliation and healing

- Vic health policy integrating past and present with disease reduction
- Ways to input indigenous knowledge into Vic health policy
- Service standards and protocols based on indigenous knowledge
- Data systems which enable accurate determination of service coverage
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1. Introduction

This literature review seeks to identify and discuss the policy implications of existing research around health and health promotion for urban Aboriginal communities. There is a broad and vibrant body of literature that explores and debates Aboriginal health and health policy in Australia and in other First Nation countries, much of which is focussed on rural and remote communities and those living apart from 'mainstream' society (Pyett et al 2009). This review does not seek to summarise the whole of this literature, but seeks to narrow the field to that which can be applied to Aboriginal people living in Victoria, a predominantly urban or metropolitan population, geographically embedded within multi-cultural cities and towns (ABS 2007). The available literature is diverse, with multiple points of convergence and divergence, and as such most policy arguments can be supported by at least a fraction of the overall body of research and commentary, as Lutschini cautions: "policy makers have to navigate and interpret a diverse health literature and assemble disparate messages into saleable policy options... policy makers can justify any answer based on the diversity of the literature, subsequent themes and range of meanings" (Lutschini 2005 p2-7).

With that in mind, it is important to highlight the limitations of this review early in our discussions: this is not an exhaustive analysis of all available positions and beliefs within the field of Aboriginal health and health policy. Neither is it without assumptions or bias: we take a human-rights based position, which emphasises the importance of social justice, and an essential need for the autonomy of, and engagement with, Aboriginal people in the governance and improvement of their/our communities. Where possible, we seek to take a holistic approach to Aboriginal health policy; both an holistic notion of health and also as an holistic, or intersectoral, notion of policy and health governance. On this latter point however, we are pragmatically limited by the structure and organisation of the health field.

Indigenous social and health disadvantage have been well documented (see for example ABS/AIHW 2008), and health policy makers in Australia face a broad range of entrenched public health problems, particularly as Aboriginal health disparities and inequities widen (Gleeson 2009). Notions of holism within Aboriginal health are widely
recognised, and relatively well established within mainstream policy machinery, for example a government-level definition of Aboriginal health from 1989 states that: “Health is not just the physical well-being of the individual, but the social, emotional, and cultural well-being of the whole community. This is a whole-of-life view and it also includes the cyclical concept of life-death-life” (Department of Aboriginal Affairs 1989). However, “there is no definitive source providing a comprehensive grounding framework to enable effective engagement with the concept of Aboriginal health” (Lutschini 2005 p2). A lack of detailed or applied understanding of the notions of holistic Aboriginal health is evident in both the social and political environment, which renders “cultural differences either invisible or too visible and something to be eliminated” (Altman 2009 p14). This invisibility is amplified in urban, metropolitan and 'mixed' areas, where Aboriginal culture is submerged within, as well as subjugated by, 'mainstream' dominant cultures. It is therefore important that there is “recognition that Aboriginal culture exists and is important in urban areas” (Kelly and Luxford 2007 p17). A need for recognition of urban Aboriginal communities, culture and health-needs is both a rationale for this review and also a finding drawn from the policy environment: urban Aboriginal people are affected by health policies, but rarely are they adequately recognised within the policy process.

The discourses of the public policy environment will shape emergent policy, and those who participate in the discourse will influence policy content (Aldrich et al 2007), therefore it is important to recognise, engage with and facilitate the participation of Aboriginal communities within commentary and advocacy for policy change. While there is a large body of literature that points to the failure of policy, “there are few examinations of policy, [or] the policy process of political decision-making for policy concerning the health of Aboriginal and Torres Strait Islander peoples” (Aldrich et al 2007 p125). This review therefore aims to draw from a diverse but acknowledged incomplete evidence base, to identify implications from existing research through a thematic analysis of literature relevant to current and future Aboriginal health policy in Victoria.

2. Method

Three sources of data were sought. Firstly, evaluations of specific policies identified in the policy review section of the Talking It Up project; secondly, primary research around health and health promotion from urban Aboriginal communities that had policy implications; and thirdly, secondary research or commentaries that critiqued the evidence base and/or policy outcomes for Aboriginal health. A search for empirical research around specific Aboriginal health policy, as well as current research around
health and health promotion for urban Aboriginal communities was conducted using all databases available through EbscoHost, including Academic Search Premier, CINAHL, Global Health and Medline. Search terms were: Aborigin* or Indigenous AND health AND Australia* (where "**" is a truncation term that allows for multiple variations of the root word, for example Australia* would identify Australia and Australian and Australians). A sub-set of the search was limited to urban or metro, to filter out research only conducted within very remote communities. The publication date was limited to 2000 onwards, in line with the earliest year of introduction of current Aboriginal health policy, as identified in the policy review. Grey literature was searched for using Google Scholar, and the titles of existing policies (identified in the policy review) were used as search terms through the main Google search engine, to identify other commentaries or evaluations available through grey or other non-peer reviewed sources.

Articles were included in the literature review if they were evaluations of specific policy, evidence-based commentaries on specific policies, empirical research into Aboriginal health with a policy focus or commentaries on the general Aboriginal policy environment. At the outset of the literature search, there was an anticipated hierarchy across this inclusion list, with the greatest importance placed on evaluations of specific policies. However, the literature search highlighted that much of the available literature was at the other end of our perceived hierarchy (not specific to individual policies and/or without an empirical basis linked to policy outcomes), and we had to revise some of our assumptions about what was informative for future Aboriginal policy development. Many of the commentaries discussed here are insightful and highlight many problems and unresolved issues across the field of Aboriginal health, which are essential considerations for appropriate policy development. In this way, advocacy and consciousness raising are as important as rigorous testing of policy-specific activities or interventions in this review.

In line with the key areas identified in the policy review, one the initial aims of the literature review was to monitor Aboriginal peoples’ involvement in research and commentary-making (parallel to “ATSI involvement” – see policy review). At the outset of the literature review, one of our assumptions was that, where divergent arguments were made, voices that came from or were endorsed by the Aboriginal community would be privileged over those that had no Aboriginal participation. However, this too had to be revised across the literature search and review process, as it became clear that it was almost impossible to identify Aboriginal authorship (this was rarely and inconsistently articulated), and in turn this raised doubts for us that it was culturally appropriate to question the Aboriginal credentials of individuals. Thus we chose to set aside two of the common tools used in literature reviewing; that of a data hierarchy and that of a publication hierarchy.
Articles identified by the search strategy and included for review were read and thematically analysed, identifying key themes in the literature. These are discussed in the following sections of the literature review.

3. Literature Overview

Five themes were identified in the literature:

1. Tension between statistical equality and valuing cultural difference and diversity
2. Measurability: culturally appropriate measures, benchmarks, targets and timeframes within the context of increased power and control for Indigenous people
3. Policy does not address structural inequities and determinants
4. Recognition of historical and cultural context, social settings: Collaboration as Reconciliation
5. Policy Cycle: process and delivery

These are summarised in Figure 2.1, and discussed in more detail in the following sections. An earlier version of this diagram was included in a summary report circulated to the community for feedback and community comment. A full copy of the draft literature review was available in the interim report discussed at the second round of consultation. Feedback was generally supportive, but minor revisions have been made to improve the clarity and appearance of the diagram. Conclusions were reformulated to frame tensions in the evidence-base as questions for practice.
Figure 2.1: Thematic Diagram from Literature Review

What are the policy implications of existing research around health and health promotion for urban Aboriginal communities?

- Equality and difference
  - Remedialism, bringing Aboriginal people 'up'
  - Recognition of unique and 'good'
  - Context: historical, social and cultural
  - Collaboration
  - Self-determination
  - Legacy of colonisation

- Reconciliation and history
  - Plans agreed by Aboriginal people
  - Identifying people as Aboriginal

- Culturally appropriate policy
  - Accountability & transparency
  - Use & mis-use of data

- Social structures and inequities
  - Poverty and powerlessness
  - Social determinants

- Policy making and doing
  - Policy vs practice
  - Workforce & services
  - Consultation & partnerships
  - Evaluation & research
4. Tension between statistical equality and valuing difference and diversity

There are several strong voices within the literature that express a tension between statistical equality and valuing cultural difference and diversity within policy. These voices stem particularly from commentary around the Close the Gap policy. Often policy broadly aims to bring Aboriginal health ‘up’ to the standard of White or non-Indigenous Australian health, providing evidence of the “persistent white/western faith in the power of the scientific method to heal social ills” (Pholi et al 2009 p9). This goal of normalising Aboriginal people has an inherent threat of assimilation and fails to recognise or celebrate cultural differences in health patterning.

The pursuit of statistical equality “reduces Indigenous Australians to a range of indicators of deficit, to be monitored and rectified towards government set targets...illustrating a substantial imbalance of power and control over the Indigenous affairs agenda in Australia” (Pholi et al 2009 p1). Current Aboriginal health policy is dominated by the idea of statistical equality, and whilst at face value there should be no gap between Indigenous and non-Indigenous Australians, these commentators argue that effective Aboriginal health policy should accommodate and value diversity and difference rather than emphasising statistical equality (Altman 2009; Pholi et al 2009). Altman (2009) suggests that the pragmatic politics of equality is over-determining Aboriginal health policy, while the more complex and subtle politics of difference and diversity is being excessively subordinated (Altman 2009). In order to measure progress, Close the Gap relies on comparable data and therefore anything that may be uniquely positive about being an Aboriginal or Torres Strait Islander person is of little relevance to the ‘evidence base’ as there is no comparable data set within the non-Indigenous population (Pholi et al 2009).

The politics of the gap have swung heavily towards remedialism and the imposition of authoritarian solutions, with frustration and intolerance of the long-standing tension between equality and difference (Altman 2009; Pholi et al 2009). There are a number of arguments against this approach. Altman (2009) highlights these specifically, and these include the post-development theory that interprets the Close the Gap framework as “just an antiquated form of imposing a top down modernisation approach on Indigenous subjects” (Ferguson 2006 as cited in Altman 2009 p7). Anthropologies of development are critical, seeing such “universalistic top-down approaches as disruptive of local solutions and cultures, and fundamentally reflecting a discourse of power” (Escobar 1995 as cited in Altman 2009 p7). Culturalist/relativist critiques state that the approach “only uses the social norms of the dominant society, and so fails to value different life worlds and social norms whether in remote or metropolitan Australia” (Peterson 2005, Cowlishaw 2009 as cited in Altman 2009 p7).

Humpage 2005 (as cited in Altman 2009) states that the Close the Gap approach is used “as a means to legitimise state intervention, to define Indigenous difference as
in need of remedy, to mainstream non-Indigenous standards, and to avoid acknowledging Indigenous notions of outcomes that might include self-determination, autonomy and self governance” (Humpage 2005 as cited in Altman 2009 p7).

Whilst Altman (2009) and Pholi et al (2009) focus their commentary on Close the Gap, there are similar arguments within commentary on Indigenous Drug and Alcohol policy. Brady (2007 p762) states that current drug and alcohol polices have seen “a retreat from the recognition and endorsement of the special, different needs of Indigenous people, and a return to notions of equal treatment and integration with the Australian collectivity”. This argument is supportive of those situated within commentary of the broader Close the Gap framework. Alongside these arguments are critiques that describe how social indicators can be culturally inappropriate, and whilst this will be more specifically discussed in the following section, the statistical indicators with which progress in closing the gap will be measured represent Indigenous Australia not as a society, but as a population comprised of individuals.

Statistics focus on averages of individuals, and so present a statistical fiction of subjects as independent of kinship or community social settings and the dynamics within Aboriginal and Torres Strait Islander societies, as well as the structural conditions, and relationships of power and control between Indigenous and non-Indigenous Australia (Taylor 2008 as cited in Altman 2009; Pholi et al 2009). It is with this in mind and the ambiguous interpretations of statistical data that Altman (2009) asks the question of what is it that we are seeking to measure within the Close the Gap framework, and is it a sound basis for policy? Altman (2009 p6) states that the statistical goals of Close the Gap “become somewhat rhetorical and hollow if they are not matched by effective policy action or analysis of the causes of socio-economic difference, and if such goals do not reflect Indigenous aspirations”. The poor recognition of socio-economic and structural determinants of Indigenous health must also be examined, and there is a compelling argument throughout the literature for greater emphasis on and recognition of these factors within the policy environment. A more detailed discussion of this is presented in future sections.

To summarise, this theme identified in the literature reflects a small number of firm voices that call for a policy framework that does not sacrifice either equality or difference. Altman (2009 p15) articulates that this policy framework would be “based on more coherent and inclusive notions of equality and difference”, and is somewhat comparable to the Indigenous policy environment that exists in New Zealand. Recommendations for this policy framework include the notion of equality however this refers to equality and equity, “although difference in outcomes is inevitable” (Altman 2009 p15). Secondly, the framework needs to encompass the notion of difference, with “Indigenous-specific programs negotiated on social justice and human rights principles. Such rights should countenance the option for voluntary exclusion as strategic choice” (Altman 2009 p15). Thirdly this policy framework
needs to incorporate the notion of historical legacy, and that should involve compensatory measures. Altman (2009 p15) acknowledges that this policy framework would be challenging and difficult to sell politically, but that “it is essential if we are to transcend the insidious homogenisation embedded in the Close the Gap approach, and instead seek to pursue a kind of multiculturalism that can seriously accommodate and value Indigenous diversity and difference”.

As outlined in the next section, the tension between statistical equality and cultural diversity and difference is most clearly articulated in the limited benchmark targets that are utilized within policies: highly individualised and with an emphasis on socio-economic status and biomedical data points to the exclusion of Aboriginal understandings of health and wellbeing.

5. Measurability: culturally appropriate evidence base, measures, benchmarks, targets and timeframes within the context of increased power and control for Indigenous people

Measurability was identified as a persistent theme within the literature, and incorporates a number of strands and tensions. Specifically these include problems associated with data quality, the absence of data and measurability and the cultural appropriateness of data, measures and benchmarks, each of which are discussed further.

Data Quality
National data remains flawed in relation to Aboriginal and Torres Strait Islander people and the accurate identification of Indigenous status. The problems associated with data quality “limit our ability to accurately establish and monitor comparative secular trends between populations” (Brown 2009 p97). There is concern surrounding the difficulties in collecting, and thus the completeness, quality and accuracy of, Aboriginal and Torres Strait Islander statistical data, particularly in mortality, hospitalisations and health datasets, and across and within jurisdictions with the largest Aboriginal populations (Anderson 2006a; Anderson 2006b; Brown 2009; Jackson Pulver and Fitzpatrick 2004; d’Abbs and Brady 2004; Mak 2008).

Anderson (2006b p21) notes that the ability of the Aboriginal and Torres Strait Islander Health Performance Framework, which was designed to measure the impact of the National Strategic Framework for Aboriginal and Torres Strait Islander Health, will “be limited by the availability of appropriate quality data for reporting, a major factor of which is the inconsistent recording of Indigenous status/territories, although this is improving”.

Absence of data and incomplete data
The policy-making process is complex and politicised, however when the opportunity for policy reform arises, public health research and evidence has an important place
(Nutbeam and Boxall 2008). Whilst most policy change is incremental and based on a mix of influences, increased value placed on evidence will be most likely if evidence is “available when needed, is communicated in terms that fit with policy direction, and points to practical actions” (Nutbeam and Boxall 2008 p748). As a consequence of poor data quality surrounding Aboriginal and Torres Strait Islander people, much of the policy commentary points to an avoidance of data altogether, thus influencing the measurability of Aboriginal health policy. The success of Aboriginal health policy requires improved data collection and the ongoing development of shorter and longer term action plans and benchmarks that are agreed to by Aboriginal people (Jackson Pulver and Fitzpatrick 2004).

Aboriginal health policy typically lacks benchmarks or measures, but is also influenced by the quality and appropriateness of the evidence base. However, as identified by Altman (2009 p2) in commentary on Close the Gap, even when policy articulates specific objectives such as reducing the gap in mortality rates for children under five; reading writing and numeracy levels; year 12 attainment rates; and employment outcomes, the term “closing was used a little loosely, if realistically, to mean halving”. Despite having objectives, there are questions of their measurability and ability to be monitored over time, and the appropriateness of reducing but not eradicating disparity or disadvantage of Indigenous populations.

Policy recommendations relating to the National Drug Strategy Aboriginal and Torres Strait Islander Peoples’ Complementary Action Plan focus on better compilation of coronial data from different jurisdictions in order to provide a national collection of statistics on the impact of petrol sniffing and other inhalants on morbidity and mortality given the paucity of data in this area (d’Abbs and Brady 2004). There are problems identified within the evidence base used to inform the National Drug Strategy Aboriginal and Torres Strait Islander Peoples’ Complementary Action Plan. d’Abbs and Brady (2004 p259) recommend that the evidence base, particularly relevant to petrol sniffing, could be increased by “utilising one or more of the existing national drug research centres” and that this would highlight the difficulties in collecting such data and provide the basis for a formal national collection of statistics on the impact of petrol sniffing and other inhalants on morbidity and mortality. Similarly, there is some commentary around Aboriginal health policy that targets drug abuse, and it is noted that there is a lack of fit between funding and evidence-based interventions for substance misuse (Gray et al 2006). It is also noted that evaluation of Indigenous-specific policies, programs and interventions is limited, and that those that have been conducted are of variable quality (Gray et al 2006; Dance 2004).

In the absence of reliable data, and limited benchmarks and targets for Indigenous health policy, what data is relied upon is not always culturally appropriate. Altman (2009 p14) highlights that there has been “no negotiation of agreed objective and no
evidence that the policy juggernaut is countenancing “flexible tailored local solutions”.

Cultural Appropriateness
There is widespread acknowledgement and acceptance of holistic definitions of Aboriginal health within the policy literature, however “there is little general or specific detail about what this means and the implications for the health system” (Lutschini 2005 p2). As discussed in the previous section, there is a tension between statistical equality and valuing diversity, which results in conflict and tensions in other areas of the literature. The tension between reductionism and holism, and benchmarking versus experienced equity, is evident in the literature body. AIHW data is weighted heavily towards risk factor reduction and health service provision, and the statistical orientation of closing the gap reduces Indigenous Australians to a range of indicators of deficit, and does not allow for the enormous complexity of diverse, Indigenous, culturally-distinct, ways of being (Altman 2009; Pholi et al 2009; Nutbeam and Boxall 2008).

There is tension between the collection of health performance indicators to facilitate health policy and planning and the role of indicators in fiduciary accountability (Anderson et al 2006b). The evidence base that guides Indigenous health policy is typically quantitative and is based largely on biomedical and socio-economic indicators, and as such “is the starting point and the guide to action, to the point where action may only be undertaken where there are data available to support it” (Pholi et al 2009 p3). Policy makers must engage with holistic notions of Aboriginal health in order to set culturally appropriate benchmarks that reflect community aspirations whilst ensuring human rights provision and accountability (Lutschini 2005; Jackson Pulver and Fitzpatrick 2004). The targets identified will require significant commitment and investment in implementation, and a key strategy for reducing the disparities in Indigenous health would be to address structural power imbalances, increasing Indigenous control over their circumstances (Brown 2009; Pholi et al 2009; Ring and Brown 2002). “The framework for monitoring progress would include a substantial suite of indicators measuring the degree to which power and control increase and is collectively exercised within Indigenous Australia” (Pholi et al 2009 p5). This notion of collective voices will again be picked up in later sections.

6. Policy does not address structural inequities and determinants

Indigenous health disparities are predominantly related to other ‘diseases of poverty’ and it is the familiar principles of ‘equal opportunity’ that compels governments to ensure that no ‘category’ of citizen suffers worse life chances than other categories (Couzos 2004; Rowse 2009). “Indigenous Australians, as a category, do suffer worse average life chances, so public policy must respond” (Rowse 2009 p3).
Aboriginal people in Australia are “on the negative extreme of basic indicators of health and well-being, such as life expectancy, educational attainment, and incarceration rates” (Johnston et al 2007 p490) however, Australian health policy does not typically address the social determinants of health (Nutbeam and Boxall 2008).

Whilst it is recognised in previous sections that Aboriginal health policy must include targets, funding and timeframes that are culturally appropriate, it is also recognised in the literature that data has become both the means and the ends. It is the statistical gaps within inappropriate measures that define the targets for policy action (Altman 2008). Such a policy approach, though ‘evidence based’ is virtually devoid of theory and exists outside of historical, social and cultural context, measuring what is reducible and feasible rather than measuring determinants of health or health outcomes (Calma 2007; Pholi et al 2009; Anderson et al 2006b). It is imperative that policy attention is directed towards areas such as health, education, housing, welfare reform, and employment, and that these policy areas are addressed with both short and longer-term strategies (Jackson Pulver and Fitzpatrick 2004).

Research conducted by Lloyd et al (2008 p181) that explored the role of the health workforce in implementing Aboriginal health policy, states that “addressing the social determinants of health and community development were seen as the most important aspects to improving Aboriginal health”.

There are broad calls for a greater focus on the structural inequities and social determinants influencing Indigenous health outcomes, and these broad principles have also been highlighted in commentary surrounding a few select policy documents and policy areas. Specifically, the importance of the social determinants and broad structural inequities has been highlighted in three Aboriginal policy areas: Close the Gap, the National Drug Strategy Aboriginal and Torres Strait Islander Peoples’ Complementary Action Plan and the National Strategic Framework for Aboriginal and Torres Strait Islander Health, the details of which are outlined below.

Commentary surrounding Close the Gap emphasises its failure to acknowledge that poverty is a symptom of powerlessness, and hence fails to address the structural sources of inequality and how they might be rectified (Li 2007 as cited in Altman 2009). Other commentary indicates that it is the absence of a critical focus on structural inequities, collective power and control, and the dynamics of the relationship between Indigenous Australia and the rest of the nation, that means the policy will be “unlikely to achieve healthy Indigenous Australian societies, adequately equipped to manage and sustain the health of its members” (Pholi et al 2009 p6).

Literature that examines the National Drug Strategy, with a particular emphasis on sniffing and inhalants states specifically that petrol sniffing is “too complex an issue to be addressed through short-term pilot and project funding; it requires, rather, longer-term interventions that address the multiple risk and protective factors present
in communities, and that build on programmes that have been shown to be effective” (d’Abbs and Brady 2004 p259). There are parallels with The National Strategic Framework for Aboriginal and Torres Strait Islander Health, which has been described as being “measuring what is feasible as opposed to measuring determinants of health or health outcomes” (Anderson et al 2006b p7).

This theme highlights agreement within both broad and specific policy commentary that the structural, social and historical determinants influencing Aboriginal health are omitted from the policy process, and that this must fundamentally inform future policy, as discussed further in the next section.

7. Recognition of historical and cultural context, social settings: Collaboration as Reconciliation

“Sickness, expatriation from ancestral land, and poverty are all manifestations of the collision of worlds and cultures” (Johnston et al 2007, p489) and there are a number of voices in the literature that argue for the importance of recognition of this historical context and social settings. The current Aboriginal health policy environment does not sufficiently target or acknowledge upstream determinants and causes, and symptomatic of this is the downstream, post-diagnosis service focus within the policy environment. Three particular issues are noted as particularly embedded within the current context of Indigenous affairs and yet inadequately addressed by policies: colonisation, self-determination and reconciliation.

Legacy of Colonisation
As discussed in the previous section, the social determinants and structural inequities influencing Aboriginal health must be recognised; however these cannot be viewed as a “technical problem with no history” despite the preference for doing so by the settler-colonial state (Altman 2009 p14). It is broadly recognised that Aboriginal health is holistic, and that it encompasses mental, physical, cultural and spiritual health (NACCHO 2003). It is important that there is historical openness about the concept of Indigenous rights (Rowse 2009), and more specifically, “to recognise the link between Aboriginal and Torres Strait Islander people’s burden of illness and the anxiety, anger and grief resulting from separation from country, cultural destruction and genocide is the first step towards significant and lasting change” (Jackson Pulver and Fitzpatrick 2004 p193).

A number of authors within the literature recognise the importance of the historical and cultural context, and argue that our shared history must be acknowledged within the broader community and within the policy environment (Jackson Pulver and Fitzpatrick 2004; Johnston et al 2007; Altman 2009). This shift in focus to the broader, non-Indigenous community is central to the arguments around recognition of structural and social determinants. It forms the idea that the focus should be on
the wider community and society, rather than directing all attention at Indigenous community groups and their ‘problems’. Pholi et al (2009) provides a pertinent argument that there is no measure of the prevalence of racism or discrimination towards Indigenous people within the broader Australian population. Pholi et al (2009 p5) goes on to state that “because no broader social problem or structural inequities are measured, there is no evidence of a broader problem to be addressed”. This is linked to the implications of measurability as highlighted in the previous section.

Rowse (2009 p2) states that because of the circumstances of the settler colonial nation-state, Indigenous Australians have suffered systematic abuse and that our “unfortunate history has given their human rights a distinct content and pertinence”. He goes on to state that “they are the colonised, not the colonisers and justice demands that the colonised and colonisers negotiate a relationship of consent” (Rowse 2009 p2). Given these circumstances, it is recognised within the literature that there must be a shift in community attitudes along with the acknowledgement of our shared history, otherwise the current experiences of racism or low sense of control over life circumstances for Indigenous individuals remains just that, an individual problem (Pholi et al 2009; Jackson Pulver and Fitzpatrick 2004). Kaplan-Myrth (2005) argues that while some non-Indigenous Australians experience guilt and shame as a result of shared history, they are not willing to go much further than that. This perspective, in which the broader, non-Indigenous community is the focus, is supported by Edwards and Taylor (2008 p32) who state that policy must be critiqued for potentially disempowering language and practices, and thus require “non-Indigenous people to change their responses”. Edwards and Taylor (2008) highlight that decolonisation would require an examination of ‘us and them’ language division, and that this would provide an opportunity for social justice within policy and practice. Therefore this argument for a shift in attitudes is required not only in the broader community, but within the health and policy environments and would require “an unpacking of history and preconceptions, and recognition that our professions, healthy policy and services, are founded upon and privilege western cultures and world views” (Edwards and Taylor 2008 p32).

The literature includes broad calls for the recognition of historical context. However, this theme is also recognised more specifically in a small number of research studies, critiques or commentary papers surrounding specific policy, as outlined below. Research surrounding the National Oral Health Plan highlighted that participants portrayed how “ongoing cultural adaptation was required to cope with the social and emotional impact of colonialism, living in missions, the stolen generation, loss of land, processes of assimilation and sustained disempowerment” (Jamieson et al 2007 p54). Community members felt that historical legacy impacted on the health, including oral health, “mainly through continued practices of being told what to do, where to live, how/when/if they would receive government money and what health services were available to them” (Jamieson et al 2007 p54). Participants
felt they had “little power over their oral health or oral health care decisions” (Jamieson et al 2007 p54). Recommendations from this research are that strategies must incorporate the “influence of historical legacy/cultural adaptation, and the downstream factors resulting from this” into the provision of Indigenous health services and health education/promotion programmes (Jamieson et al 2007 p58).

Systematic and sustainable improvements in Indigenous health and social disadvantage require self-determination for Indigenous people, and collaboration as reconciliation within the context of recognition and responsibility for our shared history. This is discussed in the following two sections.

**Self Determination**

A number of strong voices within the literature state that protocol and policy must be centred on basic human rights and, given Australia’s difficult history, for Aboriginal people “these basic human rights are indissolubly linked to the right to self-determination and the right to development” (Jackson Pulver and Fitzpatrick 2004 p194). It is evident in the literature that there is tension between the notion of self-determination and collaboration, and the view of governments that self-determination implies a hands-off approach. Self-determination for all people is supported by international law, “which as well as conferring the choice to determine their own political status is the basis upon which Indigenous peoples may share power within the existing state” (Jackson Pulver and Fitzpatrick 2004 p194). Kaplan-Myrth (2005) states that there is a tension between outcomes and processes for governments in relation to Aboriginal health. Kaplan-Myrth (2005 p75) goes on to highlight within both state and federal governments, that there is an “overwhelming desire for health outcomes that will stand up to public scrutiny” and that in order to achieve these goals governments recognise the need to collaborate with Indigenous communities. It is acknowledged that there are two specific policy responses occurring in respect of reconciliation, firstly whole of government approaches and secondly partnerships between governments and Indigenous communities (Jackson Pulver and Fitzpatrick 2004). However, there is criticism that within their approach to collaboration, and in order to achieve health outcomes that will stand up to public scrutiny, governments will “look for ways to establish practical relationships with the community controlled sector, while avoiding the muddy impractical waters of Aboriginal empowerment and self-determination” (Kaplan-Myrth 2005 p75).

Inherent in this is the argument that whilst government rhetoric centres around self-determination and the expression of support for Aboriginal community empowerment, Kaplan-Myrth (2005 p75) states that there is ambivalent vacillation between this and “in the same breath, paternalistic expressions of concern about how much control can realistically be relinquished to Aboriginal people”.

It seems that given the historical context within which these issues are raised, there is tension between the notion of self-determination and the interpretation of this by
governments as a hands-off approach. Fundamental within these arguments is the idea that governments appear to support and acknowledge the importance of self-determination, however as a bottom-up, community based focus that fundamentally renegotiates power between governments and Aboriginal communities, there remains an unwillingness to relinquish power to Aboriginal people (Jackson Pulver and Fitzpatrick 2004; Kaplan-Myrth 2005). The process of self-determination and thus reconciliation must see Indigenous groups have the power to effectively take responsibility for decision-making processes and in order for this to occur, there must be fundamental institutional and structural changes (Kaplan-Myrth 2005; Jackson-Pulver and Fitzpatrick 2004).

Collaboration as Reconciliation

Whilst much of the literature speaks of both self-determination and the need to recognise the historical and social settings within which Aboriginal health occurs, much of the literature is focused around the practical implications of this for collaboration and partnerships with diverse Aboriginal communities in the policy cycle as well as the reconciliation process. The following section highlights the implications of historical context and the importance of both recognition and responsibility for collaboration as reconciliation.

Kaplan-Myrth (2005) highlights that the efforts of Aboriginal and non-Aboriginal people involved in Aboriginal health politics, and thus the pioneers of inter-sectoral and intergovernmental policy collaboration, have achieved tangible and quantifiable outcomes. Specifically these are recognised in lower rates of hospitalisations, decreases in rates of infectious diseases, better chronic disease management, successful immunization programs in Aboriginal communities, and the improvement of Aboriginal health curricula within medical schools (Kaplan-Myrth 2005). Whilst this is acknowledged as a step towards practical reconciliation, there remains an expectation by governments, policy makers and health professionals, that Aboriginal people accept mainstream values (Kaplan-Myrth 2005). It is the role of governments to facilitate and assist Aboriginal communities to achieve their goals without taking over the process (Jackson Pulver and Fitzpatrick 2004). Whilst the area of partnership building is critical to sustainable development, it is most effective when the Indigenous party is the dominant party responsible for determining “policy objectives and strategies and controls the way they are achieved by means of processes and institutions that the community respects and which reflect the group's cultural values (Jackson Pulver and Fitzpatrick 2004 p195). This suggests that despite the premise of community-government partnerships, that “contemporary relationships are still, fundamentally, rooted in and informed by Australia’s colonialist history with all of its attendant institutions, structures, and practices” (Kaplan-Myrth 2005 p69; Jackson Pulver and Fitzpatrick 2004).

“Despite bureaucratic initiatives and an emphasis on partnerships, Aboriginal critics of reconciliation point out that the Australian public—and by extension government—
has not let go of the vestiges of colonialist mentality” (Kaplan-Myrth 2005 p73). Whilst holistic notions of health are recognised, less understood is the importance and centrality of land to wellbeing: “Crucially, it must be understood that when the harmony of these interrelations is disrupted, Aboriginal ill health will persist” (Lutschini 2005 p4). Johnston et al (2007) highlights that the fundamental nexus of Aboriginal wellbeing and their land is inherently missing from policy, and suggests a number of reasons for this. Specifically, Johnston et al (2009) states that despite the recognition of Aboriginal legal rights to land and natural resources, the testimony of Aboriginal people is often given less weighting, particularly in medical settings, in terms of evidence used as a basis for policy development. As well as the notion that Aboriginal voices are largely discounted within policy debate and that any presentation of these voices by non-Indigenous people is open to bias and selective reporting, Johnston et al (2007 p496) also states that culturally specific issues of health, place, wellbeing and identity are “complex and difficult subjects to discuss without the appropriate context and experience”.

The development and application of policy must be negotiated and implemented within the context of, and with acknowledgement of, the “diverse histories, cultures and social settings of the communities in which it is applied” (Gray et al 2006 p187). In summation, the long term effects of colonisation has impacted on both self determination and reconciliation, thus collaboration and respectful engagement are important to address and support both self-determination and the reconciliation process. The following section, which focuses on the policy cycle, and includes discussion of collaboration, partnerships and engagement with Aboriginal communities at various stages within the policy cycle, is framed by the arguments of some Aboriginal critics of reconciliation who suggest that the both the Australian public and the Australian government have “not let go of the vestiges of colonialist mentality” (Kaplan-Myrth 2005 p73).

8. The Policy Cycle: Process and Delivery

As highlighted in the previous section, the importance of collaboration with Aboriginal communities is significant within the literature. Whilst the previous section focused specifically on the need for collaboration as reconciliation, this section will focus on collaboration at all stages of the policy cycle. This discussion is born from a body of literature that emphasises the importance of collaboration and partnerships, however highlights this at all stages of the policy cycle – from conducting research with Aboriginal communities, to policy design, implementation and evaluation. As the policy process is cyclical, there can be iterative tensions. A multitude of different actors with different agendas are expected to contribute to the policy cycle, however within the policy focussed Aboriginal health literature, these are exacerbated by the divergence between ‘white’ policy machinery and Aboriginal communities. This literature also highlights the call for more practical guidelines for policy
implementation, drawing attention to the limited number of practical recommendations for policy implementation in the available literature. Whilst there are useful and applicable recommendations for the implementation of policy, they are available in only a limited number of issue-focused areas, thus ensuring the fragmentation of Aboriginal health that contravenes more holistic notions of Aboriginal health and wellbeing. With the emergence of good practice for policy implementation in some areas, these are fractured and not sustainable without recognition of both the historical context and the underlying determinants and inequities that contribute to these health issues, as highlighted in previous sections, thus the recommendations remain downstream and post-diagnosis.

It is evident that there are disconnects between research and policy recommendations, good practice and good policy, and downstream post-diagnosis service provision versus upstream determinants and notions of being holistic. These tensions are discussed in the following sections.

**Collaboration and partnerships**
The literature review identified broad policy recommendations emphasising the importance of partnerships and collaboration with Indigenous communities. Indigenous people must be involved at all stages, including policy and program development, implementation and evaluation. It is acknowledged that Aboriginal communities and organisations are able to participate in health policy processes through both formal and informal mechanisms, however Kaplan-Myrth (2005 p80) states that policy processes and partnership relationships must be “no longer improvised or, left up to the whims of individuals”. There is also a persistent argument from representatives of the Aboriginal community controlled health sector emphasising the importance of strengthening these mechanisms in order to ensure that Aboriginal communities and organisations are able to “harness more power within partnership relationships so that they will have greater influence on health policy and programs” (Kaplan-Myrth 2005 p80).

Whilst the importance of cooperation and collaboration with Aboriginal communities has been identified, it is also argued within the literature that government departments must also be responsible for improved communication and collaboration within and between departments. Collaboration must include improved communication and the possibility for agreement to be reached between federal, state and local government levels, departments and roles in order to support the process of evidence-based health policy and the efficient coordination of resources in implementing a holistic model of health care (d’Abbs and Brady 2004; Gray et al 2006; Dugard 2006; Brown 2009). Whilst collaboration within and between governments, departments and Aboriginal communities is discussed in the broader policy literature, there are also some specific recommendations linked to particular policies. Whilst they have different health priorities and operate in their own clinical settings, the details of these are outlined below.
An evaluation of the inclusion of injury and injury prevention within The National Strategic Framework for Aboriginal and Torres Strait Islander Health identified that it “was endorsed as a plan to guide all Australian governments in a coordinated, collaborative and multi-sectoral approach to achieving Aboriginal and Torres Strait Islander health gain over the next decade” (Anderson 2004, p3). However, Anderson (2004 p3) highlights that its implementation does not have specific funding attached, whilst also noting “although arguably, the roll-out of the Primary Health Care Access Program will provide additional capacity to the implementation of the National Framework”. In relation to injury prevention and safety promotion within this framework, Anderson (2008) observes some commitment to data respect, however questions the commitment to building safe environments, community capacity for safety promotion and the necessary inter-sectoral relationships. Anderson (2008 p60) recommends that these “vertical or issue-focused strategies as such in injury are coherently articulated with the broader strategic agenda and their impact maximised”.

In an examination of the policy response to petrol sniffing among Indigenous Australians, it was identified that it must be possible for agreement to be reached between relevant departments at one level of government, and between levels of government at multiple stages (d'Abbs and Brady 2004). d'Abbs and Brady (2004 p259) recommend that a “coordinated approach to the provision of resources, based on systematically reducing risk factors in inhalant-prone environments should be implemented”. They argue that there is a perception that “government agencies can sit back and insist that communities take ‘ownership’ of the problem, and that all governments need to do is provide intermittent grants to community groups [and that this] needs to be exposed and rejected” (d'Abbs and Brady 2004 p159). They recommend that communities must be partners in any program to address petrol sniffing that there must be a genuine partnership approach involving government, non-government and community sectors, committed to collating, utilizing and building on evidence of effectiveness, in order to address the personal and community damage caused by petrol sniffing (d'Abbs and Brady 2004).

It is both this literature and the broader policy commentary that highlight collaboration within and between government departments and communities as critical in the policy process for improving Aboriginal health.

Policy recommendations from research in urban Aboriginal communities
There is a paucity of policy focused research around health and health promotion for urban Aboriginal communities despite more than half of the Indigenous population living in urban and regional centres (Pyett et al 2009). The majority of public health research is devoted to descriptive studies that only occasionally offer direct solutions to policy problems (Nutbeam and Boxall 2008), and as such there are few specific policy recommendations observed from the existing policy focussed literature around
health and health promotion for urban Aboriginal communities. The existing literature around Aboriginal health and health promotion is largely focused on rural and remote communities, thus the complex and differing health needs of urban Aboriginal communities are overlooked in the research and thus existing Aboriginal health policy. In comparison to remote and some rural communities, urban Aboriginal communities are “less homogenous, are not geographically discrete, and may not have a single central community organisation or council that can be referred to for guidance in research” (Pyett et al 2009 p52). Urban areas can provide a meeting place for people across many different cultural groups, therefore there is diversity in the cultures and beliefs across a geographic community, such as a service area (Kelly and Luxford 2007). There are well noted rivalries between different Aboriginal tribes, but also between urban, rural and remote communities and the current policy environment does not reflect this diversity (Lutschini 2005). This empirical evidence base exploring urban Aboriginal communities is ideally where we sought to obtain policy recommendations. Whilst this literature review is not exhaustive, it is evident that there is an imbalance in the available research and literature in the current policy setting.

**Research with urban Aboriginal communities**
Broader political agendas are often reflected in policy debates about Aboriginal issues, and thus good evidence is required to advance these debates (Johnston et al 2007). There is a small body of literature identified that focuses on the role of research with Aboriginal communities, and the importance of collaboration and community consultation and involvement as advisory groups or partners in research (Pyett et al 2009; Leon de la Barra et al 2009; Jackson Pulver and Fitzpatrick 2004). Positive partnerships are identified by Jackson Pulver and Fitzpatrick (2004 p197) as “those that brought Aboriginal community representatives around the table with government and high-quality research institutions to implement a community defined, health research agenda”. Whilst Leon de la Barra et al (2009) argue that current health policy ignores the evidence base that does exist, Nutbeam and Boxall (2008) argue that it is often the media and language with which public health research findings are presented that exclude policy makers from considering their importance.

With reference to the research process, Pyett et al (2009) recommend that there must be adequate consultation with Aboriginal communities before approval or support for a project is sought. “Too often researchers contact community organisations with a research proposal requiring a letter of support so they can submit it for funding or ethics approval, but they have not begun to consult with any representatives of the relevant community” (Pyett et al 2009 p52). Pyett et al (2009) goes on to note that whilst community consultation has been a recommendation for policy documents and ethics guidelines, it is now explicitly required and supported by the National Health and Medical Research Council.
Leon de la Barra et al (2009) states that with the emergence of self-determination and community controlled services, Aboriginal people began to demand that research evidence be fed back to the community as it was felt that nothing was being done ‘on the ground’. This is supportive of the notion that previous research has been “too focused on the priorities and career objects of researchers rather than the priorities of communities and, as such, had been an impediment to sustaining partnerships and programs” (National Health and Medical Research Council 2003 as cited in Jackson Pulver and Fitzpatrick 2004 p197). Leon de la Barra et al (2009) states there is a need for new initiatives to build capacity among researchers from Indigenous backgrounds, and recommends the community and researchers continue to advocate for the provision of funding for liaison positions, promotion of tools for collaboration or support for research training staff in Aboriginal Medical Services as valuable capacity building strategies. International models such as those from Canada and New Zealand are recommended as best practice models to draw from in order to build capacity among Indigenous researchers (Leon de la Barra et al 2009). Leon de la Barra et al (2009) also identifies that even when federal policy documents do recommend building research capacity, there is a failure to include specific implementation plans and indicators for assessment, a theme consistent with other sections within the literature review.

Policy Design
Within the Indigenous policy design process, there must be collaboration and partnerships with Indigenous communities and the development of Aboriginal-led, evidence-based policy (Lloyd et al 2008; Jackson Pulver and Fitzpatrick 2004). Aboriginal and non-Indigenous societies are heterogeneous and as such, contain a multiplicity of health concepts. Policy makers must have a greater understanding of holism in Aboriginal health in order to “engage meaningfully and confidently with Aboriginal concepts of health” (Lutschini 2005 p7). Nutbeam and Boxall (2008 p753) recommend that public health practitioners and advocates seeking to influence policy outcomes need to “understand and participate in the policy-making process; present their research in ways that fit with the political context of the day; and where necessary, use research evidence in public health advocacy in order to influence political priorities more directly”. It is recognised that more attention must be given to the processes of health policy and strategy development in order to ensure the adequate inclusion and consideration of holism and Aboriginal concepts of health (Lutschini 2005).

In reference to commentary surrounding the National Strategic Framework for Aboriginal and Torres Strait Islander Health in which the consistent application to the commitment to the principle of cultural respect is questioned, collaboration and involvement of communities is recommended in policy design (Jackson Pulver and Fitzpatrick 2004). This collaboration would thus result in “community focused solutions based on human rights principles” and will also ultimately contribute to community wellbeing (Jackson Pulver and Fitzpatrick 2004 p198).
Policy Implementation
There is a persistent voice within the literature that identifies shortfalls in the implementation of Aboriginal health policy (Leon de la Barra et al 2009; Westerman 2004; Brown 2009; Lloyd et al 2008; Anderson 2004). Brown (2009 p99) articulates that "despite awareness of what should be delivered, the mechanisms by which to achieve significant improvement remains elusive". Policy implementation can happen at a number of levels, and the following section will highlight that "although there is a considerable body of evidence identifying the steps in developing effective public policy, there is less evidence to guide implementation" (Lloyd et al 174).

Jackson Pulver and Fitzpatrick (2004 p194) state that "making power sharing real for Indigenous peoples involves capacity development, for individuals and communities, and the control to freely and meaningfully participate in developing and implementing policies and regimes that affect their own lives". Specifically, the literature identified centres around implementation of policy within service delivery and provision, and incorporates the role of the health workforce in this implementation.

Westerman (2004 p1) identified “at the system level, services struggle with embedding/incorporating culturally appropriate practice within policy and procedural frameworks”. Lloyd et al (2008 p179) also recommended that more Aboriginal people need to be employed as health professionals as “the cultural and local knowledge, skills, experience and community connectedness, combined with clinical and population health knowledge and skills” were viewed as essential to effective implementation of policy and to the achievement of positive health outcomes over time. These arguments highlights that Aboriginal people continue to be under-represented in the health workforce particularly in higher level positions, and that effective, efficient implementation of health policy requires adequate Aboriginal representation at all levels of the health workforce (Lloyd et al 2008).

Other problems were identified in the transition from policy to practical implementation within service provision and service delivery, such as is highlighted by Lloyd et al (2008) in exploring the chronic disease policy implementation process. Lloyd (et al 2008) not only identified that consultation with communities and Aboriginal health workers was ad hoc and that they were typically excluded from the policy development process, but also revealed a number of structural and workforce issues associated with policy implementation. Implementation of chronic disease policy within the health workforce was dependent on support from health service management, and on structural support that saw the creation of dedicated chronic disease positions (Lloyd et al 2008). There is recognition that a skilled workforce must have roles that are congruent with achieving policy goals but also that Aboriginal health workers were under greater pressure from families and communities, but received little practical and professional support (Lloyd et al 2008). Recommendations by Lloyd et al (2008 p181) in the role of the health workforce in chronic disease policy implementation are that implementation must happen in the community rather than the clinic and focus on the broader determinants; the
workforce must be strengthened and that this includes support, training, greater representation of Aboriginal health professionals and decreasing staff turnovers that “erode trust and undermine the sustainability of interventions”; increased power and respect for Aboriginal health workers afforded by other health professionals and more champions in the bureaucracy for Aboriginal health workers.

**Evaluation of services, programs and policy**
Johnston et al (2007 p496) states that there “remains a remarkable paucity of evaluation of the efficacy of various Aboriginal programs or policy initiatives”. Leon de la Barra et al (2009) agrees there is a need for continued improvement of current Indigenous policies through review and monitoring of their impact, but identifies that most research still focuses on describing the health problems or causes rather than testing interventions. Where intervention research does exist, it tends “to concentrate on risk factor modification rather than the wider social, economic and environmental determinants of health” (Nutbeam and Boxall 2008 p750). These voices are heard throughout the literature, and Pholi et al (2009) argues that policy makers should be attempting to measure and monitor progress in the delivery of power and control over the Indigenous affairs agenda into the hands of Indigenous Australians. This highlights ongoing issues within the cyclical nature of policy and its ongoing motion. There are multiple points where there can be multiple problems, as highlighted in the preceding section, however with greater engagement and evaluation the cycle may be broken.

**9. Conclusions**

The literature review has identified a number of points of convergence and divergence within the policy focused literature around Aboriginal health and wellbeing. There is agreement throughout the literature that there must be greater collaboration, evaluation, monitoring and accountability for Aboriginal health, and within this, equitable and holistic notions of health must be both recognised and celebrated. However, the literature raised, and left unanswered, a number of questions and unresolved tensions, particularly around practical issues of policy construction and delivery.

1. How do we assess and document Aboriginal health in a way that is simultaneously measurable, culturally appropriate and comparable over time and between areas?

It is acknowledged within the literature that there must be greater accountability for Aboriginal health. This includes both measurability and evaluation of Aboriginal health. However, there remains a tension between statistical equality and cultural diversity, where the goal of remedialism to ‘bring up’ Aboriginal people to the standards of non-Indigenous Australians people fails to recognise or celebrate cultural differences in health patterning. The focus on health outcomes (particularly
life expectancy) as the major indicator of Aboriginal wellbeing fails to incorporate
ing important cultural and historical perspectives, which would allow for greater
recognition of, and emphasis on, historical and structural determinants of health.

2. How do we delivery genuinely intersectoral, holistic health policies, across
health, housing, justice, education, community development, employment,
transport and cultural sectors? How do we balance whole-of-community
responsibility and collaboration with community-centred control and choice?
The notion of holism is widely discussed within the literature, including holism as an
extension of the biomedical model of health to include wider determinants and
meanings of wellbeing, as well as holism as incorporating community, cultural
practices and structures within and across services sectors. However the literature
does not provide clear guidance about how to achieve this. Situated within this are
unresolved tensions between the need for Aboriginal peoples and communities to be
empowered and in control of their own health, and the need for governments and the
whole-of-community, including non-Indigenous Australians, to take responsibility for
their role as well. The literature does not address how self-determination, power and
control for Indigenous people can be achieved at the same time as working together,
and collaboration with policy makers and service providers.

3. How does the whole-of-community work towards redressing social, structural
and historical inequities? How can sustainable reconciliation and social justice
for Aboriginal communities be achieved?
The literature highlights the urgent need to address structural and underlying
inequity, at both an upstream, policy level as well as a downstream, community level.
Aboriginal health policy tends to segregate Aboriginal from non-Aboriginal people,
which broadly fails to recognise the role of non-indigenous Australians in the
improvement and delivery of Aboriginal health, and the realities of integrated, urban
communities. The literature advocates for greater recognition and improved
understanding of Aboriginal cultures, and a change in the attitudes towards
Aboriginal peoples across the whole of the (non-Indigenous) community. However, it
remains unclear how racism and discrimination can most effectively be challenged,
how power can be shifted more equitably, and how reconciliation can be sustained.

These five questions, in the context of advocacy, collaboration, equity and
accountability, may not have the same answers in all parts of Australia and for all
Aboriginal communities. Good policy development needs to consider these
questions and try to balance these tensions as part of the construction of community-
and culturally-appropriate policies and guidance, and would require community
consultation and participation of local communities within the policy process. The
need for participatory research and engagement within the development of good and
healthy policies for healthy Aboriginal communities is particularly recommended.
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<td>3d</td>
<td>Department of Human Services Aboriginal Services Plan 2008-2010</td>
</tr>
<tr>
<td>3e</td>
<td>Aboriginal Cultural Competence Framework</td>
</tr>
<tr>
<td>3f</td>
<td>Because Mental Health Matters: Victorian Mental Health Reform Strategy 2009-2019</td>
</tr>
<tr>
<td>3g</td>
<td>A Plan for Action 2005 – 2007 Promoting Mental Health and Wellbeing</td>
</tr>
<tr>
<td>3h</td>
<td>Strong Culture, Strong Peoples, Strong Families: towards a safer future for Indigenous families and communities 10 year plan</td>
</tr>
<tr>
<td>3i</td>
<td>Aboriginal Child Placement Principle Guide</td>
</tr>
<tr>
<td>National Aboriginal Health Strategy 1989</td>
<td>278</td>
</tr>
<tr>
<td>References</td>
<td>280</td>
</tr>
</tbody>
</table>
Introduction

Health policies are the decisions, announcements and documents that guide and govern health delivery. These include health-related frameworks and strategies, which give direction to health service providers and regulators. In Australia, “health policy is a big field... There is certainly no master plan...There has been a constant stream of reforms pursued at regional state and national levels, some of which have created change and some not” (Dugdale 2008, pages 1 and 13). Policy is the way in which health sector practices change when laws and Acts of Parliament stay the same. Policy communicates priorities, ethos and principles; policies are the interpretation of evidence and best practice, and form the basis of the contemporary objectives for service management and delivery. Policies articulate how health should be delivered, regulated and accounted for.

For the purposes of this review, only published documents that come from health related departments at the Federal or Victorian state level are included. Policies that do not extend beyond announcements or decision-making, i.e. are not implemented or disseminated sufficiently for others in the health sector to follow, are not included. Therefore this review seeks to analyse the policy documents that form the shared policy environment for the health sector, its workers and its clients. The widest conceptualisations of health would mean that all policies at all levels of governance would need to be considered, although this was clearly outside of the scope of the Talking It Up project. Therefore, this review seeks to analyse policies from within the health sector, and in particular those policies which are identified as guiding Aboriginal or Indigenous health.

It is important to consider the policy environment as this is one of the most important points of communication and negotiation between those in control of health delivery, those responsible for delivering health, and their clients. That communication and negotiation is often one-way, or heavily weighted in favour of those setting and producing policies; however, it is also empowering for communities to know what has been said about how they should be treated, and policies, when produced well, can be empowering for service users and clients.

Method

The policy review was a detailed process of collecting and documenting the policies that govern and guide Aboriginal health in Victoria. This includes national policies and frameworks, as well as those specifically from Victoria. The first part of the
process was to identify the policies that govern Aboriginal health. It was not possible to find a single-site summary of health policies relevant to Aboriginal health, so policies were collated from a range of sources. These included Australian Policy Online (www.apo.org.au); Victorian Government Online (www.vic.gov.au); Department of Health and Aging (www.health.gov.au); and Department of Families, Housing, Community Services and Indigenous Affairs (www.fahcsia.gov.au). Policies were included if they were: current, specified a remit for Indigenous or Aboriginal health; existed in a policy document as a policy, framework, strategy or guidelines. Policies were excluded if they were only applicable to states or territories outside of Victoria, or if they did not have a remit or a specific and substantial policy for Aboriginal or Indigenous health. In total, 15 Federal/ national policies and 9 Victorian/ state policies were identified. An additional policy, the National Framework for Aboriginal Health 1989, was initially excluded because it was not current implemented, although it became useful in later stages of analysis as it remains influential in the policy environment. A Fairer Victoria 2008 and A Fairer Victoria 2009 are included in the review, as both were considered current across the course project; however only the 2009 policy is included in the third stage of analysis as the most up-to-date policy.

The next stage of the review process was to conduct an initial analysis, summarising the policies, frameworks and strategies against a criteria that aimed to identify key aspects. The criteria covered the extent to which the policy governed Aboriginal health (which level of government, its jurisdiction and who it applies to, its longevity and for how long it applies, its level of impact as guiding or obligatory); its aims and rationale (what it sets out as its objectives and why); what outcomes it seeks and whether these will be monitored; how it proposes to implement its aims; how much money has been allocated to achieving its aims; and additional key points about what actions will be done and by whom. The full criteria are presented in Figure 3.8. This criteria-based analysis is presented in the second part of the review, with each policy presented in its own sub-section. The exact wording from the policy documents has been used wherever possible. Occasionally, we have summarised available information to answer the review criteria. Text that is not directly quoted from the policy documents is printed in a lighter colour, like this.

Not all of the criteria were clearly addressed in the policy documents, and in particular, there is a lack of clearly stated plans for implementation or plans to achieve the aims that are set out, and a lack of plans to monitor or to review the impact and outcomes of a policy. Where information is not readily or clearly available in the policy documents this is denoted as 'Not clearly specified'.

The second stage of the analysis was to identify the relationships between the policies. Sometimes this was very clear, where policy documents state that they are guided by or build upon the principles of existing frameworks; or where later strategies are the implementation plans of earlier frameworks. Sometimes the
relationship was less clear. These relationships were mapped and a full, but somewhat complicated, database was produced which located each of the policies presented here and their stated inter-relationships. This is presented in Appendix 4. To simplify the presentation of this analysis, each policy has its own relationships presented in a diagram at the start of its policy sub-section.

The third stage of the policy analysis was to compare the policies against each other, along dimensions of interest indentified by the literature review and community forums. These dimensions included: the extent to which Aboriginal people and communities had been involved or consulted in the policy process; the extent to which policies indicated an integrated policy environment; and the extent to which policies were informed or guided by principles of good practice for Aboriginal health (specifically the National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003- 2013). This analysis used a variation of the ‘heat mapping’ technique. All of the policies were arranged in a grid across the two layers of national or state level. A simple coding process attempted to answer the questions of ‘to what extent’ participation, integration and guidance by principles of existing frameworks were identified in the policy documents. This coding was represented visually by using a gradient of shading; deeper shading represents a greater extent. Heat mapping has the advantage of using categorical data in a way that is indicative of a gradient without needing to use numerical data, and therefore supports indicative comparisons across a variety of data sources.

Finally, the findings from the policy review were circulated to the participants and co-researchers. The summary diagrams of the policies and the extent of Aboriginal participation, and diagrams of inter-relationships between four of the policies were circulated to all participants that had provided postal addresses in the summary report (see Appendix 4). The interim report contained an earlier draft of all three stages of the analysis and this was discussed at the second round of community consultation, attended by interested participants. On the basis of feedback from the co-investigators and community members several revisions were made to improve the clarity of the presentation of the analyses. This included moving the complex spreadsheet of relationships to the appendices for reference, and developing the individual diagrams of each policy to be larger and presented across two facing pages, so that the relationship ‘blobs’ and the lists of non-relationship were more easy to view. The interpretation of the policy environment as a whole was refined, to reflect community input and an additional heat map was produced to capture ‘what else’ the policies were related to, outside of the immediate Aboriginal health field. This was identified as important, so that policies that were identified as not clearly related to others in the review were not inadvertently portrayed as completely disconnected from other policies. This additional analysis was illuminating, as it emphasised how Aboriginal health policy can be influenced by other policies that were not produced with Indigenous communities in mind.
Limitations

Without an up-to-date and comprehensive national or state repository of Aboriginal health policies, it is possible that there are omissions from this review, for example, policies that we need not identify and did not realise were missing. In some sections of the criteria-based analysis, we entered ‘not clearly specified’. It may be that the information is available elsewhere but not explicitly linked to the policy document, and simply not identified within the search and collation process. Similarly, some of the inter-relationships between policies are coded as ‘not clearly stated’. This may also be explicitly stated outside of the policy documents under review here and not adequately captured by the summarising process. Finally, our use of the original text in the criteria-based analysis was chosen so that the meaning of the policy was kept throughout the reductive process of summarising the key points of the documents; however, this faithfulness to the phrasing of documents may have limited the comparability of the policies for the reader following through the sub-sections.

Findings

Findings about the policy environment emerged through the analysis process. Firstly, it was found that the full range of policies and strategies that govern and guide health for Aboriginal people is not easily available, and that there is no accessible index to help people (as community, clients or professionals) find out what principles and policies are in place. The first of the ‘maps’, Figure 3.1, summarises the policies that were included in the analysis here. Secondly, the mapping exercise revealed that few individual policies are well integrated, and that the policy environment for Aboriginal health is quite fragmented (see Appendix 4 for policy mapping). This was demonstrated visually by the mapping and the subsequent production of individual diagrams of the relationships between policies, presented throughout the policy summaries in the second part of this review.

Four questions were specifically addressed by heat map analysis, presented in the following Figures 3.2-3.7

1. To what extent is there clearly documented Aboriginal participation and/or consultation in the development of the policy or strategy; and how is this described in the policy documents?

Participation, and ownership, of health policy is important for generating policies that are empowering, culturally appropriate and avoid paternalistic approaches to improving health. It is important for policy makers to consult with the communities they seek to influence; and important for policy writers to recognise and document
this in the policy documents. Descriptions of community participation or consultation were extracted from the policy documents, and coded in four levels, ranging from formalised participation in the development of the policy; through community consultation; to proposed consultation; to none specified (this last code may represent both non-participation and also non-reporting of participation). This is displayed in Figures 3.2 and 3.3. Similar extents of Aboriginal participation were documented at the national level compared to the state level, as well as similar rates of no clearly documented participation.

2. To what extent is the National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003 – 2013 integrated within the policy environment?

The current National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003- 2013 is broadly the ‘gold standard’ of Aboriginal health policy, with extensive Aboriginal participation in its construction, and sets the direction for health and health reform across all levels of governance. A strong policy environment would integrate the National Strategic Framework across subsequent policies, as being guided by, building on or seeking to implement the principles of the framework. Stated relationships were extracted from the policy documents, and coded across three levels: clear relationship; relationship stated by unclear; no clearly stated relationship. This is displayed in Figure 3.4. The National Strategic Framework is more clearly articulated as integrated within national policies, compared to the state level policies.

3. To what extent are national policies informed by the National Aboriginal Health Strategy 1989; and to what extent are state policies informed by the Victorian Indigenous Affairs Framework?

Given the varying extent to which the current National Strategic Framework guides the policy environment, as identified in the second question above, it was important to consider what other frameworks were influential. During the mapping of relationships between the policies it became clear that the National Aboriginal Health Strategy 1989 remains influential and guides current policy, even though later policies have effectively superseded it. Additionally, the Victorian Indigenous Affairs Framework is important for Victorian state policies. Therefore, the extent to which both of these policies are currently integrated in Aboriginal health policy was explored, and the findings are presented in Figure 3.5. The 1989 strategy is nearly as integrated as well the current national strategy, and is clearly still guiding policies at the national level. At the state level, the Victorian Indigenous Affairs Framework is slightly more clearly articulated as integrated in policies than the National Strategic Framework.
4. Which policies are not connected to other Aboriginal health policies discussed here; and which other policies are related to current Aboriginal health policy?

The health of Aboriginal peoples and communities is influenced by a wide range of policy decisions and implementation. A strong policy environment is not only clearly guided and well integrated; it is also related to and embedded within wider policy structures. With this in mind, the policies included in the analysis were coded as either clearly connected to at least one other policy reviewed here, or not clearly related to other policies in the analysis, based on the policy mapping. This is presented in Figure 3.6 (see Appendix 4 for further details of the policy mapping). There were more policies at the state level that were coded as not clearly related to other policies in the analysis, compared to the national level. Overall, more policies were integrated in the body of policies reviewed here than were not.

Following this, all of the policies were assessed to consider what additional policies and guidelines were articulated as related or guiding. This is presented in Figure 3.7. This was important to understand the ways in which current Aboriginal health policy is connected to other policies, and to avoid created a false impression that some of the policies under review are disconnected or isolated from all other policies. All of the policies included in the analysis articulated relationships with at least one other policy. At the national level, some of the policies were integrated within the policies reviewed here, and no additional policies were explicitly related. This was not found at the state level. The analysis also revealed that ‘mainstream’ or non-Indigenous-specific policies are influential and connected to the current Aboriginal health policy environment. Of the five policies that were not explicitly related to other policies in the review, three articulated being guided by United Nations policies (convention, covenants and declarations).

Conclusions

There are some examples of good practice across the policy environment, but this is inconsistent. Participation and consultation with communities has been highlighted as particularly important in both the literature review and the participant forums, and formalised participation structures have been established in some, but not all, of the policy development documented here. Some policies are guided by the current National Strategic Framework, some by the National Strategy 1989, some by the Victorian framework, and some by United Nations human rights frameworks; but again this is inconsistent. Aboriginal health policies are not disconnected from ‘mainstream’ or non-Indigenous counterparts, and may be as influenced by them as by Indigenous-specific frameworks. It is important therefore that policy makers at all levels of governance consider the effects of their decisions on Aboriginal communities, who may be secondary consumers of their policies through the shared policy environment, and consider carefully how to engage with Aboriginal communities in the construction of good, health policies.
### Figure 3.1: Policies included in the analysis

Policy analysis: national and state policies, frameworks and strategies that inform or govern Aboriginal health in Victoria

<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>2</td>
<td>Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework</td>
<td>Framework for Reporting on Indigenous Disadvantage</td>
<td>Cultural Respect Framework for Aboriginal and Torres Strait Islander Health</td>
<td>Good practice framework. Policing illicit drugs in rural and remote Aboriginal and Torres Strait Islander communities</td>
</tr>
</tbody>
</table>

Rows 1-4 are National policies, frameworks and strategies  
Rows 5-6 are Victorian policy and frameworks
**Figure 3.2: Documented participation in the development of policies**

Is there clearly documented Aboriginal participation and/or consultation in the development of the policy or strategy?

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework</td>
<td>Framework for Reporting on Indigenous Disadvantage</td>
<td>Cultural Respect Framework for Aboriginal and Torres Strait Islander Health</td>
<td>Good practice framework. Policing illicit drugs in rural and remote Aboriginal and Torres Strait Islander communities</td>
</tr>
</tbody>
</table>

Rows 1-4 are National policies, frameworks and strategies
Rows 5-6 are Victorian policy and frameworks
Darker shading = more, formalised participation
Figure 3.3: Descriptions of participation

How is Aboriginal participation and/or consultation specified in the policy document?

<table>
<thead>
<tr>
<th>Prepared by the National Aboriginal and Torres Strait Islander Health Council for the Australian Health Ministers’ Conference</th>
<th>Developed by the Standing Committee on Aboriginal and Torres Strait Islander Health</th>
<th>Not specified.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Aboriginal and Torres Strait Islander Health Workforce Working Group is charged with planning, implementation, coordination and monitoring</td>
<td>Consulted widely with Indigenous organisations, governments and researchers. The insights gained from Aboriginal and Torres Strait Islander people will be reflected in the next report.</td>
<td>Widespread consultation.</td>
</tr>
<tr>
<td>National Aboriginal and Torres Strait Islander Males Health and WellBeing Reference Committee... meetings and conferences around the country</td>
<td>Based on consultations with Aboriginal and Torres Strait Islander stakeholders</td>
<td>Not specified.</td>
</tr>
<tr>
<td>Government needs to involve Indigenous people in the design and delivery of programs locally and regionally, and share responsibility for outcomes.</td>
<td></td>
<td>The Aboriginal and Torres Strait Islander Peoples’ Reference Group was established to negotiate the development of this action plan.</td>
</tr>
<tr>
<td>Forums will in future involve ... ongoing representation of Aboriginal communities.</td>
<td>Would not have been possible without contributions from Aboriginal signatory organisations, a range of staff in Aboriginal Community Controlled Organisations, through regional Aboriginal advisory groups and through individual consultations</td>
<td></td>
</tr>
<tr>
<td>An Indigenous people advisory group.</td>
<td>Not specified.</td>
<td>Victorian Aboriginal Child Care Agency (VACCA) was commissioned.</td>
</tr>
<tr>
<td>Written with assistance from the Department of Human Services, Indigenous Initiatives Unit team.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Rows 1-4 are National policies, frameworks and strategies
Rows 5-6 are Victorian policy and frameworks

Darkest shading = formalised participation in developing or writing the policy
Mid-shading = community consultation or advisory groups
Lightest shading = proposes participation
Figure 3.4: Influence of the National Strategic Framework

Integration of the National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003 – 2013 within the policy field

<table>
<thead>
<tr>
<th>Row 1</th>
<th>Row 2</th>
<th>Row 3</th>
<th>Row 4</th>
<th>Row 5</th>
<th>Row 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003 - 2013</td>
<td>Aboriginal and Torres Strait Islander Health Performance Framework</td>
<td>National Framework of Principles for Government Service Delivery to Indigenous Australians</td>
<td>National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Well Being: 2004 - 2009</td>
<td>Good practice framework. Policing illicit drugs in rural and remote Aboriginal and Torres Strait Islander communities</td>
<td></td>
</tr>
<tr>
<td>Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework</td>
<td>Framework for Reporting on Indigenous Disadvantage</td>
<td>Cultural Respect Framework for Aboriginal and Torres Strait Islander Health</td>
<td>Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005 – 2008</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A National Framework for improving the health and wellbeing of Aboriginal and Torres Strait Islander Males</td>
<td>Be active Australia: a framework for health sector action for physical activity 2005-2010</td>
<td>National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan 2000 - 2010</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Aboriginal Child Placement Principle Guide</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Rows 1-4 are National policies, frameworks and strategies
Rows 5-6 are Victorian policy and frameworks

Dark shading = guides, informs or builds on; integrates principles or implementation
Light shading = relationship stated but not specified
No shading = no clearly stated relationship between the policies
**Figure 3.5: Influence of the 1989 National Strategy and the current Victorian Framework**

Integration of the National Aboriginal Health Strategy 1989 (national) and the Victorian Indigenous Affairs Framework (Victoria)

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework</td>
<td>Framework for Reporting on Indigenous Disadvantage</td>
<td>Cultural Respect Framework for Aboriginal and Torres Strait Islander Health</td>
<td>Good practice framework. Policing illicit drugs in rural and remote Aboriginal and Torres Strait Islander communities</td>
</tr>
</tbody>
</table>

Rows 1-4 are National policies, frameworks and strategies
Shading = builds on or is informed by the 1989 National Aboriginal Health Strategy

Rows 5-6 are Victorian policy and frameworks
Shading = relationship with the Victorian Indigenous Affairs Framework
**Figure 3.6: Policies not clearly related to other policies in the analysis**

Policies not clearly related to the other Aboriginal health policies reviewed in this analysis

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework</td>
<td>Framework for Reporting on Indigenous Disadvantage</td>
<td>Cultural Respect Framework for Aboriginal and Torres Strait Islander Health</td>
<td>Good practice framework. Policing illicit drugs in rural and remote Aboriginal and Torres Strait Islander communities</td>
</tr>
</tbody>
</table>

Rows 1-4 are National policies, frameworks and strategies
Rows 5-6 are Victorian policy and frameworks

Shading = not clearly related to other policies included in this review
Figure 3.7: Other policies related to the policies in the analysis

Additional policies and guidelines related to the Aboriginal health policies reviewed in this analysis

<table>
<thead>
<tr>
<th>Framework agreements; COAG reconciliation framework</th>
<th>National Health Performance Framework</th>
<th>See policy links diagram</th>
<th>National Mental Health Plan 2003-08</th>
</tr>
</thead>
<tbody>
<tr>
<td>See policy links diagram</td>
<td>See policy links diagram</td>
<td>Aboriginal Deaths in Custody; Ways Forward; Bringing Them Home; Health is Life</td>
<td>National Drug Strategy</td>
</tr>
<tr>
<td>State and Territory agreements on ATSI health</td>
<td>Eat Well Australia; Healthy Weight 2008; Preventing Chronic Disease; National Injury Prevention Strategy; National Environmental Health Strategy</td>
<td>Eat Well Australia; Framework agreements</td>
<td>National Drug Strategy</td>
</tr>
<tr>
<td>United Nations declaration on the Rights of Indigenous Peoples</td>
<td>NHMRC Road Mao; National Public Health Partnership; Primary Health Care Access Program; National Rural Health Alliance</td>
<td>National Drug Strategy; Framework agreements</td>
<td>National Drug Strategy</td>
</tr>
<tr>
<td>Mental Health Promotion Plan 1999-2002</td>
<td>COAG Action Plan on Mental Health; Care in your community; Victorian Charter of Human Rights; Vulnerable Youth Framework; Aging in Victoria</td>
<td>Growing Victoria Together; Aboriginal Justice Agreement; Children Youth and Families Act; A Way Forward; Aboriginal Human Services Plan</td>
<td>Protocol between VACCA and DHS CPS; UN Convention on the Rights of the Child</td>
</tr>
</tbody>
</table>

Rows 1-4 are National policies, frameworks and strategies
Rows 5-6 are Victorian policy and frameworks

Shading = not clearly related to other policies included in this review
Policy review

The remainder of this chapter considers the first and second stages of analysis, reviewing policy documents against criteria, detailed in Figure 3.8, and presenting diagrams to represent the relationships and integration between the policies, strategies and frameworks.

**Figure 3.8 Criteria for Policy Review**

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governance</td>
<td>Which level of government? Which Department?</td>
</tr>
<tr>
<td>ATSI involvement</td>
<td>Have Aboriginal Australians been involved in the development or implementation of this document? Who? How? I.e. was it individuals (who), communities and/or Aboriginal Organisations</td>
</tr>
<tr>
<td>Jurisdiction</td>
<td>Who does it apply to? Who is bound by it? E.g. other parts of government, organisations receiving certain funding, etc.</td>
</tr>
<tr>
<td>Longevity</td>
<td>When was it introduced/ published? When does it run from/to?</td>
</tr>
<tr>
<td>Level of impact</td>
<td>Obligatory or guiding?</td>
</tr>
<tr>
<td>Relationship to other instruments</td>
<td>Does it refer to any other policies or strategies? Which ones?</td>
</tr>
<tr>
<td>Aim</td>
<td>What does it set out to do? Include mission and/or purpose statements where available.</td>
</tr>
<tr>
<td>Rationale</td>
<td>Why are they doing this? What problems or issues is it seeking to address? Is there anything specific about the methodology they are using that is relevant to ATSI people?</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Does the document seek specific outcomes or targets? What are they and how will they be measured? How were they identified? Is there a timeframe for when they need to be achieved by?</td>
</tr>
<tr>
<td>Key points/aspects</td>
<td>What will be done and by whom? Focus on specific actions and requirements</td>
</tr>
<tr>
<td>Implementation</td>
<td>How does the document propose achieving its aims and outcomes? Who else is involved in the implementation (i.e. other organisations, departments, etc)</td>
</tr>
<tr>
<td>Review processes</td>
<td>Are there specific review processes? Have any reviews been conducted and if so, what were the main findings?</td>
</tr>
<tr>
<td>Outcomes to date</td>
<td>What has happened so far? Is there any outcomes data available and what does this say about the effectiveness of the instrument? (May not be available if recently introduced)</td>
</tr>
<tr>
<td>Amount of money allocated</td>
<td>Is it a commitment? Who is the money going to? Is it for a specific program?</td>
</tr>
</tbody>
</table>
# List of Acronyms used in the policy review

<table>
<thead>
<tr>
<th>A</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACCHS</td>
<td>Aboriginal Community Controlled Health Services</td>
</tr>
<tr>
<td>AHMAC</td>
<td>Australian Health Ministers’ Advisory Council</td>
</tr>
<tr>
<td>ATSI</td>
<td>Aboriginal and Torres Strait Islander</td>
</tr>
<tr>
<td>ATSIIC</td>
<td>Aboriginal and Torres Strait Islander Commission</td>
</tr>
<tr>
<td>ATSIHPF</td>
<td>Aboriginal and Torres Strait Islander Health Performance Framework</td>
</tr>
<tr>
<td>ATSIHPFR</td>
<td>Aboriginal and Torres Strait Islander Health Performance Framework Report</td>
</tr>
<tr>
<td>ATSIHWNSF</td>
<td>Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework</td>
</tr>
<tr>
<td>ATSIHWWG</td>
<td>Aboriginal and Torres Strait Islander Health Workforce Working Group</td>
</tr>
<tr>
<td>ATSISHBBVS</td>
<td>Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy</td>
</tr>
<tr>
<td>B</td>
<td>Be Active Australia</td>
</tr>
<tr>
<td>C</td>
<td>Council of Australian Governments</td>
</tr>
<tr>
<td>CRFATSIH</td>
<td>Cultural Respect Framework for Aboriginal and Torres Strait Islander Health</td>
</tr>
<tr>
<td>D</td>
<td>Department of Human Services</td>
</tr>
<tr>
<td>F</td>
<td>Framework for Reporting on Indigenous Disadvantage</td>
</tr>
<tr>
<td>I</td>
<td>Indigenous Australians Sexual Health Committee</td>
</tr>
<tr>
<td>IGCD</td>
<td>Intragovernmental Committee on Drugs</td>
</tr>
<tr>
<td>N</td>
<td>National Aboriginal Community Controlled Health Organisation</td>
</tr>
<tr>
<td>NACCHO</td>
<td>National Aboriginal and Torres Strait Islander Health Council</td>
</tr>
<tr>
<td>NAHS</td>
<td>National Aboriginal Health Strategy 1989</td>
</tr>
<tr>
<td>NATSIHC</td>
<td>National Aboriginal and Torres Strait Islander Health Council</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>-------------</td>
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</tr>
<tr>
<td>NATSINSAP</td>
<td>National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan</td>
</tr>
<tr>
<td>NFIHWATSIM</td>
<td>National Framework for Improving the Health and Wellbeing of Aboriginal and Torres Strait Islander Males</td>
</tr>
<tr>
<td>NFPGSDIA</td>
<td>National Framework of Principles for Government Service Delivery to Indigenous Australians</td>
</tr>
<tr>
<td>NPHP</td>
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<td>NSFATSIPMHSEWB</td>
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<td>OID</td>
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<td>SIGNAL</td>
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<td>SNAICC</td>
<td>Secretariat of National Aboriginal and Islander Child Care</td>
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<tr>
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<td>Victorian Aboriginal Community Controlled Health Organisation</td>
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**Key to Policy Mapping**

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<td>Builds on approaches in this document</td>
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| Relationship stated but unclear | }
Relationships stated but unclear:
National Framework of Principles for Government Service Delivery to Indigenous Australians
National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Well Being: 2004 – 2009
Be active Australia: a framework for health sector action for physical activity 2005-2010.
Australia's National Oral Health Plan 2004-2013
National Drug Strategy Aboriginal and Torres Strait Islander Peoples' Complementary Action Plan 2003-2009

No clearly stated relationship with:
Good practice framework. Policing illicit drugs in rural and remote Aboriginal and Torres Strait Islander communities
National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan 2000 – 2010
Closing the Gap between Indigenous and non-Indigenous Australians
A Fairer Victoria 2009
A Fairer Victoria 2008: Strong People, Strong Communities
Aboriginal Cultural Competence Framework
Because Mental Health Matters: Victorian Mental Health Reform Strategy 2009-2019
A Plan for Action 2005 - 2007 Promoting Mental Health and Wellbeing
Strong Culture, Strong Peoples, Strong Families: towards a safer future for Indigenous families and communities 10 year plan
Aboriginal Child Placement Principle Guide
1 Policies and Frameworks - National

1a National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003 - 2013

Governance
Federal – Department of Health and Ageing

ATSI involvement
Prepared by the National Aboriginal and Torres Strait Islander Health Council for the Australian Health Ministers’ Conference (NSFATSIH, cover).

Jurisdiction
The National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003 was endorsed by the Australian and State/Territory governments through their respective Cabinet processes and signed by all Health Ministers in July 2003.¹

All jurisdictions will determine and additional structures they wish to employ and any additional stakeholders (for example service provider groups, local governments) they may wish to involve to progress the cross-portfolio commitments within their jurisdiction (NSFATSIH, page 39).

Longevity
July 2003 – 2013

Level of impact
This National Strategic Framework sets agreed directions for reform in Aboriginal and Torres Strait Islander health without imposing specific targets or benchmarks on the Commonwealth, State and Territory governments in recognition of the different histories, circumstances and priorities of each jurisdiction (NSFATSIH, page 39).

This document draws together nationally agreed strategies to address specific health problems, state and territory policies and plans and the national collaborative policy and planning frameworks within which Aboriginal and Torres Strait Islander health programs are managed today. It also identifies the key priorities (some new and some long-standing) that must be addressed within the health and community services systems (NSFATSIH, page 3).

Relationship to other instruments

National Aboriginal Health Strategy 1989

- The National Strategic Framework is a complementary document that builds on the 1989 NAHS and addresses approaches to primary health care and population health within contemporary policy environments and planning structures (NSFATSIH, page 2)
- NAHS was reprinted in 1996.
- Although never fully implemented (as indicated by its 1994 evaluation), the NAHS remains the key document in Aboriginal and Torres Strait Islander health. (NSFATSIH, page 2)

Agreements on Aboriginal and Torres Strait Islander Health (Framework Agreements)

- Provide a sustained commitment from governments to policy directions agreed between all partners at the state and territory level (NSFATSIH, page 2)
- Are an important component of this National Strategic Framework (NSFATSIH, page 2)
- Through the Framework Agreements, initiatives have commenced which address the four key areas listed below (NSFATSIH, page 2).
- National Strategic Framework is consistent with and builds on these four key areas:
  - Increasing the level of resources to reflect the higher level of need of Aboriginal and Torres Strait Islander peoples;
  - Improving access to both mainstream and Aboriginal and Torres Strait Islander specific health and health related programs which reflect the higher level of need;
  - Joint planning processes which allow for full and formal Aboriginal and Torres Strait Islander participation in decision-making and determination of priorities; and
  - Improved data collection and evaluation (NSFATSIH, page 2).


- National Strategic Framework is consistent with the Council of Australian Government’s (COAG) Reconciliation Framework (2000) which advocates a whole of government approach to addressing three priority areas:
  - Investing in community leadership and governance initiatives;
  - Reviewing and re-engineering programs and services to ensure that they deliver practical measures that support families, children and young people. In particular, measures for tackling family violence, drug and alcohol dependency and other symptoms of community dysfunction; and
Forging greater links between the business sector and Aboriginal and Torres Strait Islander communities to help promote economic independence (NSFATSIH, page 3)

Aboriginal and Torres Strait Islander Health Performance Framework 2005
- This framework has been developed to provide the basis for quantitative measurement of the impact of the National Strategic Framework for Aboriginal and Torres Strait Islander Health (ATSIHPF, foreword).

Aim
Goal
To ensure that Aboriginal and Torres Strait Islander peoples enjoy a healthy life equal to that of the general population that is enriched by a strong living culture, dignity and justice (NSFATSIH, page 7).

Aims
To achieve this goal specific aims relating to life expectancy, morbidity, mortality and the prevalence and impact of particular health conditions need to be achieved. The aims listed below relate to already agreed national performance indicators and provide the basis for measuring the impact of this National Strategic Framework on some significant indicators of health outcomes.
1. Increase life expectancy to a level comparable with non-Indigenous Australians. (NPI #5)
2. Decrease mortality rates in the first year of life and decrease infant morbidity by:
   - Reducing relative deprivation; and
   - Improving well being and quality of life. (NPI #6-10, 26, 28, 32, 48)
3. Decrease all-causes mortality rates across all ages. (NPI #50-56)
4. Strengthen the service infrastructure essential to improving access by Aboriginal and Torres Strait Islander peoples to health services (NPI #15-24) and responding to:
   - Chronic disease, particularly cardiovascular disease, renal disease, diseases of the endocrine system (such as diabetes), respiratory disease and cancers; (NPI #41, 43, 44, 54, 55, 56)
   - Communicable disease, particularly infections in children and the elderly, sexually transmissible infections and blood borne diseases (including Hepatitis C); (NPI #37, 38, 39)
   - Substance misuse, mental disorder, stress, trauma and suicide; (NPI #30, 32-36, 46, 53)
   - Injury and poisoning; (NPI #35, 42, 53)
   - Family Violence, including child abuse and sexual assault; (NPI #32, 35, 42, 53) and
   - Child and maternal health and male health. (NPI #5-10, 25-32, 47-49)
Rationale
This *National Strategic Framework* is a complementary document that builds on the 1989 NAHS and addresses approaches to primary health care and population health within contemporary policy environments and planning structures (NSFATSIH, page ii).

Outcomes
Priorities
The immediate priority areas for government action listed below have been adopted by governments following a consultation process on the Draft for Discussion released in February 2001.²

- Strengthening comprehensive primary health care
- Emotional and social well-being
  - Mental health problems and suicide
  - The protection of children from abuse and violence, including Sexual abuse
  - Responses to alcohol, smoking, substance and drug misuse
  - Male Health
- To address the pre-determinants of chronic disease in adult populations, this *National Strategic Framework* will focus in particular on:
  - Nutrition and Physical Activity
  - Child and Maternal Health
  - Oral Health
- Improving the health of Aboriginal and Torres Strait Islander peoples in custodial settings
- Data availability and quality (NSFATSIH, pp 9-11)

Key points/aspects
**GROUP A: TOWARDS A MORE EFFECTIVE AND RESPONSIVE HEALTH SYSTEM**
The Australian health system has a number of components, all of which must be responsive to the needs of Aboriginal and Torres Strait Islander peoples at the local level and must provide culturally sensitive and accessible services. Comprehensive primary health care, encompassing clinical/medical care, illness prevention services, specific population health programs for health gain, access to secondary and tertiary health services and client/community support and advocacy, is the centrepiece of the health system for Aboriginal and Torres Strait Islander peoples. (NSFATSIH, page 13)

² More details about each outcome are available in original document.
Key Result Area 1 - Community controlled primary health care services.

- Aims to continue support for adequately resourced, well-planned ACCHSs
- Advocates partnerships between community controlled health services and mainstream services to ensure that ATSI communities have access to full range of services expected within the comprehensive primary health care context.
- Supports the fundamental principles of community decision-making, influence and control over the way health services for ATSI peoples are managed and delivered.
- Focuses on building communities’ capacity to take control of and be responsible for their own health outcomes (NSFATSIH, page 14).

(NSFATSIH pages 14-16 for Objectives and Action Areas and examples of successful or promising approaches for KRA 1)

Key Result Area 2 - Health System Delivery Framework

- Identifies the actions that need to be taken at a strategic level within the health system to enhance service delivery to Aboriginal and Torres Strait Islander patients and communities within the comprehensive primary health care context, including:
  - Improving coordination between programs and services;
  - Reforming mainstream health services; and
  - Supporting Aboriginal and Torres Strait Islander participation in the planning and management of mainstream health services. (NSFATSIH, page 16)

(NSFATSIH pages 16-19 for Objectives and Action Areas and examples of successful or promising approaches for KRA 2)

Key Result Area 3 - A competent health workforce

- Recognises that substantial work on a framework for workforce reform has been undertaken by Commonwealth, State and Territory governments and the community controlled health sector in developing the Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework.
- Action now required on specific strategies to improve the training, supply, recruitment and retention of appropriately skilled health professionals, health service managers and health policy officers in both mainstream services and ACCHSs.
- Coordination of effort is required across the Commonwealth, State and Territory governments through both health and education and training portfolios, and in partnership with training providers and health sector employers to ensure the right skill mix and distribution in the health workforce and to ensure that health system reform is achievable. (NSFATSIH, page 19)

(NSFATSIH pages 19-21 for Objectives and Action Areas and examples of successful or promising approaches for KRA 3)
Key Result Area 4 – Emotional and Social Well-Being

- Aimed at enhancing the emotional and social well-being of Aboriginal and Torres Strait Islander peoples and in particular targets mental health, suicide, alcohol and substance misuse and family violence issues, including child abuse.
- Specific action to address the priority area of male health has been included in this key result area (This is in recognition of the expressed desire of Aboriginal and Torres Strait Islander males to strengthen male cultural identity and their concerns in relation to poor social and emotional well-being, substance misuse and family violence. These areas have been identified by the National Aboriginal and Torres Strait Islander Health Council as immediate priorities for government attention.)
- Recognises that there are already agreed national approaches in some of these areas and lends support to the implementation of those approaches where they exist. It suggests ways to strengthen current approaches where necessary and suggests new directions where a clear national approach has not yet been developed. (NSFATSIH, page 21)

(NSFATSIH pages 21-24 for Objectives and Action Areas and examples of successful or promising approaches for KRA 4)

GROUP B: INFLUENCING THE HEALTH IMPACTS OF THE NONHEALTH SECTOR

A responsive health system is fundamentally important to ensuring that Aboriginal and Torres Strait Islander peoples have access to the full range of health services and population health programs and can benefit from health promotion approaches. However, action in areas such as education, employment, transport and nutrition is also required if sustainable health gains are to be achieved. (NSFATSIH, page 24)

Key Result Area Five: Environmental Health.

Key Result Area Five aims to improve standards of environmental health, including housing and essential services, in Aboriginal and Torres Strait Islander communities. This key result area emphasises the collaboration needed between ATSIC and a range of other Commonwealth, State, Territory and local government agencies and authorities in improving environmental health services to Aboriginal and Torres Strait Islander communities. It supports closer links between health services and environmental health services and emphasises that Aboriginal and Torres Strait Islander peoples are entitled to the standards of service and legislative protection enjoyed by the broader Australian community. To achieve this, more culturally appropriate models of service delivery may be required. (NSFATSIH, page 25)

(NSFATSIH pages 25-27 for Objectives and Action Areas and examples of successful or promising approaches for KRA 5)
Key Result Area Six: Wider strategies that impact on health

*Key Result Area Six* aims to develop partnerships with, and obtain commitment from, other sectors whose activities impact on health. Some strategies for developing joint action are nominated. Priority is given to collaborative approaches in areas such as food and nutrition, child and maternal health, recreation and exercise, aged and disability services, education, employment, transport and prison health (NSFATSIH, page 27).

(NSFATSIH pages 27-30 for Objectives and Action Areas and examples of successful or promising approaches for KRA 6)

GROUP C: PROVIDING THE INFRASTRUCTURE TO IMPROVE HEALTH STATUS

The shortcomings of data and evidence in Aboriginal and Torres Strait Islander health and welfare is well documented. These include variability in the quality of data across jurisdictions, problems associated with poor identification of people of Aboriginal and Torres Strait Islander origin, inadequate focus on Aboriginal and Torres Strait Islander peoples in mainstream data collections and inadequate recording of evidence based approaches that are successful and sustainable. (NSFATSIH, page 31)

Key Result Area Seven: Data, research and evidence.

*Key Result Area Seven* aims to develop a more strategic approach to improving information about how well the health sector is meeting the need of Aboriginal and Torres Strait Islander peoples, including data collection, evaluation of interventions and research processes. It aims to ensure that data is consistent, analysed, published and is collected in such a way that it enables comparison across jurisdictions. It aims to improve research processes and data collections about Aboriginal and Torres Strait Islander peoples so that they inform approaches to improving Aboriginal and Torres Strait Islander health. In particular, it aims to support appropriate and practical research and data collection that:

- Involves collaboration in the design, management, evaluation and dissemination phases of the research/data collection;
- Results in changes in policy, service delivery and people’s behaviour;
- Includes a focus on communicating research/data collection findings in cross-cultural and non-academic contexts;
- Strengthens Aboriginal and Torres Strait Islander data collection and research capacity;
- Encourages multi-disciplinary and cross cultural skills and perspectives; and
- Tries to look at problems by evaluating health interventions and practices, instead of repeating the nature and scale of those problems.43

(NSFATSIH pages 31-34 for Objectives and Action Areas and examples of successful or promising approaches for KRA 7)
Key Result Area Eight: Resources and finance

*Key Result Area Eight* provides for optimal resources available for Aboriginal and Torres Strait Islander health commensurate with levels of need, based on the real costs of services and capacity to delivery health outcomes. It also aims to implement integrated funding models which allow for collaborative longer-term planning across a variety of programs and funding sources for the delivery of a comprehensive range of services responsive to locally identified needs at a regional level. (NSFATSIH, page 34)

(NSFATSIH pages 35-36 for Objectives and Action Areas and examples of successful or promising approaches for KRA 8)

Key Result Area Nine: Accountability.

*Key Result Area Nine* aims to provide increased and equitable levels of accountability to Aboriginal and Torres Strait Islander communities and to governments for the delivery and effectiveness of health services. This includes improved transparency of resource allocations and decision making and reciprocal sharing of information. (NSFATSIH, page 36)

(NSFATSIH pages 36-37 for Objectives and Action Areas and examples of successful or promising approaches for KRA 9)

Implementation

Australian Health Ministers’ Advisory Council (AHMAC) to monitor implementation of National Strategic Framework over next decade through Standing Committee on Aboriginal and Torres Strait Islander Health (SCATSIH).

- SCATSIH to ensure action taken to meet national responsibilities within health portfolios.
- AHMAC ensure appropriate liaison and collaboration between officials from other departments to progress cross-portfolio initiatives (NSFATSIH page 39).

Implementation of this *National Strategic Framework* at a state/territory and regional level will be largely the responsibility of the same joint planning forums, and will be consistent with the priorities identified by each region and jurisdiction. However, all jurisdictions will determine any additional structures they wish to employ and any additional stakeholders (for example service provider groups, local governments) they may wish to involve to progress the cross-portfolio commitments within their jurisdiction. (NSFATSIH, page 39).

Each jurisdiction will develop and publish a Strategic Framework implementation plan, including accountabilities for progressing the action areas, timeframes and reporting mechanisms, against which progress within the jurisdiction will be measured. Each jurisdiction will be responsible for determining its own specific initiatives, priorities and
timeframes. The implementation plan will be developed in consultation with the partnership structures established under its Framework Agreement (NSFATSIH, pages 4 and 39).

Implementation of this National Strategic Framework at a state/territory and regional level will be largely the responsibility of the same joint planning forums, and will be consistent with the priorities identified by each region and jurisdiction. However, all jurisdictions will determine any additional structures they wish to employ and any additional stakeholders (for example service provider groups, local governments) they may wish to involve to progress the cross-portfolio commitments within their jurisdiction (NSFATSIH, page 39).

This National Strategic Framework sets agreed directions for reform in Aboriginal and Torres Strait Islander health without imposing specific targets or benchmarks on the Commonwealth, State and Territory governments in recognition of the different histories circumstances and priorities of each jurisdiction (NSFATSIH, page 39).

National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013 Australian Government Implementation Plan 2007-2013
Provides a list of immediate and longer-term priority actions in each Key Result Area and the lead agency responsible for these.
This has nine key result areas (see original document for reporting on each area)
1. Community controlled primary health care services
2. Health system delivery framework
3. A competent health workforce
4. Social and emotional well-being
5. Environmental health
6. Wider strategies that impact on health
7. Data, research and evidence
8. Resources and finance

Review processes
An independent mid term review of progress against the implementation plan and outcomes achieved will be undertaken and published and an independent evaluation of the National Strategic Framework’s outcomes will be conducted and published at its completion (NSFATSIH, page 4).
Health portfolios will report on progress annually to the Australian Health Ministers’ Conference and biennial whole of government progress reports will be prepared and published (NSFATSIH, page 4).

Progress with implementation of this National Strategic Framework will be monitored by the Australian Health Ministers’ Advisory Council through a joint meeting of its Standing Committee of Aboriginal and Torres Strait Islander Health and the National Aboriginal and Torres Strait Islander Health Council (NSFATSIH, page 4).

A joint meeting of SCATSIH and NATSIHC will be held annually to coordinate progress reports from each jurisdiction for submission to AHMAC. Jurisdiction progress reports will build on the existing monitoring arrangements and annual reporting processes under the Framework Agreements and on the Aboriginal and Torres Strait Islander Health National Performance Indicators. (NSFATSIH, page 39)

AHMAC will report to Health Ministers annually on progress in meeting the health portfolio objectives of this National Strategic Framework and will coordinate publicly available reports for Health Ministers on action within health and non-health portfolios every two years. As the National Strategic Framework has whole of government support, health ministers are ultimately responsible to their Cabinets for its implementation. (NSFATSIH, page 39)

Under the Framework Agreements each State and Territory has established a joint planning forum and has undertaken a process of regional planning to identify the priority needs for each jurisdiction and location. ((NSFATSIH, page 39)

Evaluation of this National Strategic Framework will be against the jurisdictional implementation plans (to be developed) covering the key result areas and the Framework’s Aims. NATSIHC will develop a plan for independent reviews of progress and will oversight commission of independent mid-term and final evaluation reports for public distribution. Both evaluations will focus on progress in implementation and outcomes achieved. (NSFATSIH, page 40)

Outcomes to date
The Aboriginal and Torres Strait Islander Health Performance Framework (HPF) is designed to provide the basis to monitor the impact of the National Strategic Framework for Aboriginal and Torres Strait Islander Health (NSFATSH) and inform policy analyses, planning and program implementation.

- Aboriginal and Torres Strait Islander health performance framework report 2006
Contains detailed analyses underlying the summary data presented in the Aboriginal and Torres Strait Islander Health Performance Framework 2006 report (AHMAC 2006).

- The HPF consists of 70 measures covering three Tiers - health status and outcomes, determinants of health and health systems performance.

Monitoring and Reporting

Reporting will record progress in areas consistent with the action areas detailed in each key result area and against the stated aims and, over time, chart each government’s progress against their own baselines (NSFATSIH, page 39).

As required under the National Strategic Framework, the Australian Government will continue to produce a qualitative report to AHMC on health portfolio progress against this implementation plan every year and on the contribution of all portfolios every two years. A further report against the Aboriginal and Torres Strait Islander Health Performance Framework will be produced in 2008 and every two years thereafter (NSFATSIH Australian Government Implementation Plan, page 9).

In its role of providing policy advice to AHMAC, the National Aboriginal and Torres Strait Islander Health Council (NATSIHC) will monitor the National Strategic Framework implementation process. The National Aboriginal and Torres Strait Islander Health Officials’ Network (NATSIHON) will retain an informal role in relation to reporting requirements. Health Council will also develop an evaluation strategy against which the National Strategic Framework for Aboriginal and Torres Strait Islander Health will be measured (NSFATSIH Australian Government Implementation Plan, page 9).

Amount of money allocated

Provision of financial resources to implement the Strategic Framework will depend on fiscal management strategies and competing funding priorities as determined by each jurisdiction’s budget processes (NSFATSIH, page 4).

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| Guided by the principles of                  | Pink |
| Share priority areas                        | Green|
| Implementation plan of framework            | Light Blue |
| Quantitative measurement of framework       | Red  |
| Implementation through this plan/strategy   | Grey  |
| To be considered/included in the planning process | Purple |
| Evaluation/monitoring tool of framework     | Orange |
| Builds on approaches in this document        | |
| Relationship stated but unclear             | Tan   |
1 Policies and Frameworks – National
1b - Aboriginal and Torres Strait Islander Health Performance Framework

Aboriginal and Torres Strait Islander Health Performance Framework

Shares priority areas with: National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–2013

Quantitative measurement of framework: National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–2013

Evaluation/Monitoring tool of framework: National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–2013

No clearly stated relationship with:
National Framework of Principles for Government Service Delivery to Indigenous Australians
National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being: 2004 – 2009
Framework for Reporting on Indigenous Disadvantage
Cultural Respect Framework for Aboriginal and Torres Strait Islander Health
Good practice framework. Policing illicit drugs in rural and remote Aboriginal and Torres Strait Islander communities
A National Framework for improving the health and wellbeing of Aboriginal and Torres Strait Islander Males
National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan 2000 – 2010
Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005 – 2008
Closing the Gap between Indigenous and non-Indigenous Australians
Australia's National Oral Health Plan 2004-2013
National Drug Strategy Aboriginal and Torres Strait Islander Peoples' Complementary Action Plan 2003-2009
Victorian Indigenous Affairs Framework - Improving the lives of Indigenous Victorians
A Fairer Victoria 2009
A Fairer Victoria 2008: Strong People, Strong Communities
Department of Human Services Aboriginal Services Plan 2008-2010
Aboriginal Cultural Competence Framework
Because Mental Health Matters: Victorian Mental Health Reform Strategy 2009-2019
A Plan for Action 2005 - 2007 Promoting Mental Health and Wellbeing
Strong Culture, Strong Peoples, Strong Families: towards a safer future for Indigenous families and communities 10 year plan
Aboriginal Child Placement Principle Guide
1b  Aboriginal and Torres Strait Islander Health Performance Framework

Governance
Federal

ATSI involvement
The Aboriginal and Torres Strait Islander Health Performance Framework was developed by the Standing Committee on Aboriginal and Torres Strait Islander Health (SCATSIH). SCATSIH was a principal committee of the Australian Health Ministers’ Advisory Council (AHMAC) which reports to the Australian Health Ministers’ Conference through AHMAC. (ATSIHPF, page 4).

Jurisdiction
This Framework has been developed to provide the basis for quantitative measurement of the impact of the National Strategic Framework for Aboriginal and Torres Strait Islander Health (ATSIHPF, page 4).

The Health Performance Framework will initially report only at a national and jurisdictional level. It may also be possible to report some measures by remoteness classification (eg ARIA) at the national level. Although the Health Performance Framework will not require reporting below the State/Territory level in its first iteration, as data quality improves it will be possible to review the capacity of the Health Performance Framework to include regional level analyses (ATSIHPF, page 39).

Longevity
Ongoing.

Level of impact
It provides the basis for quantitative measurement of improvements in Aboriginal and Torres Strait Islander health. It will indicate progress by jurisdictions against their NSFATSIH implementation plans and also provide an opportunity to streamline reporting on Aboriginal and Torres Strait Islander health and health care delivery (ATSIHPF, page 7).

Relationship to other instruments
The NSFATSIH identified a number of existing national strategies or strategies under development that provided more detailed points of reference for specific action to address Aboriginal and Torres Strait Islander health needs (ATSIHPF, page 6). See page 6 for complete list.
National Strategic Framework for Aboriginal and Torres Strait Islander Health

- Aboriginal and Torres Strait Islander Health Performance Framework developed to provide the basis for quantitative measurement of the impact of the NSFATSIH.
- The performance measures selected for the Health Performance Framework are based on the key policy questions identified in the National Strategic Framework (ATSIHPF, page 7).
- The Health Performance Framework will play a key role in the evaluation and monitoring of health performance in respect of Aboriginal and Torres Strait Islander people in Australia. It will be a key tool in monitoring the impact of the NSFATSIH. It will provide useful quantitative measurement for the mid term review at five years of the NSFATSIH (ATSIHPF, page 39).

ATSI National Health Performance Framework

- The ATSI Health Performance Framework is modelled on the National Health Performance Framework as it is the Australian endorsed framework and is consistent with the intersectoral approach outlined in the National Strategic Framework (ATSIHPF, page 7).

Overcoming Indigenous Disadvantage Report

- The ATSI Health Performance Framework will provide the basis for future developments in health system performance monitoring in other national reports such as the Overcoming Indigenous Disadvantage Report and the Report on Government Services (ATSIHPF, page 7).

Aim

The primary purpose of the Health Performance Framework is to monitor progress of the health system and broader determinants of health in improving Aboriginal and Torres Strait Islander health (ATSIHPF, page 7).

Rationale

Developed to provide the basis for quantitative measurement of the impact of the National Strategic Framework for Aboriginal and Torres Strait Islander Health (ATSIHPF, foreword).

Outcomes

The Health Performance Framework will also support the streamlining of reporting requirements across Aboriginal and Torres Strait Islander health. It will utilise and build on existing national data sources where possible and replace the existing National
Performance Indicators for Aboriginal and Torres Strait Islander Health (ATSIHPF, foreword).

This Framework will provide the basis for future developments in health system performance monitoring in other national reports such as the Overcoming Indigenous Disadvantage Report and the Report on Government Services. The Health Performance Framework will provide a meaningful and policy based report on the health status of Aboriginal and Torres Strait Islander peoples, the performance of the health system and the situation in relation to the determinants of health. Reporting against the Framework will promote:

- accountability
- informed policy
- informed research
- foster informed debate (ATSIHPF, page 7).

**Key points/aspects**
An important objective of the Health Performance Framework is to streamline existing reporting requirements and to ensure that reporting has a direct link to policy priorities. Therefore, reporting against this Framework will replace the current reports against the National Performance Indicators for Aboriginal and Torres Strait Islander Health (NPIs). While the Indicators have served well over a number of years, this Framework provides the opportunity for more focussed reporting with direct policy relevance and builds on the National Performance Indicators. The Framework also gives a focus to data development activity (ATSIHPF, page 39).

**Implementation**
Biennial reports will be produced against the measures contained in the Health Performance Framework. In order to commence reporting as soon as possible, the Framework will initially report on those measures that are currently able to be measured. Each Report will provide an update on data development activity underway as part of a process to work toward reporting against all measures. Appendix B summarises the measures to be included in the first report against the Health Performance Framework (ATSIHPF, page 39).

**Review processes**
Reports against the performance measures outlined in this Aboriginal and Torres Strait Islander Health Performance Framework will be produced biennially commencing in 2006. A number of measures are able to be reported now while others will require varying degrees of development and data improvement to enable reporting. This
process will establish priorities for data development with the aim of eventually reporting all the measures (ATSIHPF, foreword).

**Outcomes to date**

**Aboriginal and Torres Strait Islander health performance framework report 2006**

- Contains detailed analyses underlying the summary data presented in the Aboriginal and Torres Strait Islander Health Performance Framework 2006 report (AHMAC 2006).
- The HPF consists of 70 measures covering three Tiers - health status and outcomes, determinants of health and health systems performance.
- The 2008 HPF report presents trends over time showing improvements in several important measures of the health of Aboriginal and Torres Strait Islander peoples. In particular: Mortality, Infant mortality and Circulatory disease.
- However, large disparities remain because the rate of improvement has been greater for other Australians than for Aboriginal and Torres Strait Islander peoples over recent years.

(ATSIIHPFR 2008 Summary, page 7).

**Amount of money allocated**

Not specified.
1 Policies and Frameworks – National
1c National Framework of Principles for Government Service Delivery to Indigenous Australians

- Relationship stated but unclear: National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003 - 2013
- National Framework of Principles for Government Service Delivery to Indigenous Australians
- Shares priority areas: Framework for Reporting on Indigenous Disadvantage (includes Overcoming Indigenous Disadvantage reports)
No clearly stated relationship with:
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Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework
Cultural Respect Framework for Aboriginal and Torres Strait Islander Health
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Strong Culture, Strong Peoples, Strong Families: towards a safer future for Indigenous families and communities 10 year plan
Aboriginal Child Placement Principle Guide
1c National Framework of Principles for Government Service Delivery to Indigenous Australians

Governance
Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA)
COAG agreed to a National Framework of Principles (NFPGSDIA, p1)

ATSI involvement
Not specified.

Jurisdiction
Within this National Framework appropriate consultation and delivery arrangements will be agreed between the Commonwealth and individual States and Territories (NFPGSDIA, p2)

Longevity
Not specified

Level of impact
Guiding.

Relationship to other instruments
National Strategic Framework for Aboriginal and Torres Strait Islander Health.

Overcoming Indigenous Disadvantage Report
- The NFPGSDIA focuses on priority areas, including those identified in the OID report:
  - The priority areas of the Overcoming Indigenous Disadvantage Framework developed by the Productivity Commission are:
    - early childhood development and growth;
    - early school engagement and performance;
    - positive childhood and transition to adulthood;
    - substance use and misuse;
    - functional and resilient families and communities;
    - effective environmental health systems; and
    - economic participation and development
  (NSFATSIH Implementation Plan, page 50)
Aim
All jurisdictions are committed to achieving better outcomes for Indigenous Australians, improving the delivery of services, building greater opportunities and helping Indigenous families and individuals to become self-sufficient. To this end, and in delivering services to Indigenous people, the Council of Australian Governments (COAG) agreed to a national framework of principles for delivering services to Indigenous Australians.4

Rationale
In June 2004, the Council of Australian Governments agreed to a National Framework of Principles for Government Service Delivery to Indigenous Australians as part of a commitment at all levels of government to cooperative approaches between agencies to maintain and strengthen government effort to address Indigenous disadvantage. The principles address:
• sharing responsibility;
• harnessing the mainstream;
• streamlining service delivery;
• establishing transparency and accountability;
• developing a learning framework; and
• focusing on priority areas
(NSFATSIH Implementation Plan, page 50).

Outcomes
Within this national Framework appropriate consultation and delivery arrangements will be agreed between the Commonwealth and individual States and Territories (NFPGSDIA, page 2)

Key points/aspects
See rationale.

Implementation
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 2003.5

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.\(^6\)

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.\(^7\)

**Review processes**
Not specified.

**Outcomes to date**
N/A – principles are there to guide service delivery.

**Amount of money allocated**
Not specified.

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National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being: 2004-2009

Implementation plan of framework:
National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003 - 2013

Guided by the principles of: National Aboriginal Health Strategy 1989

Builds on approaches in this document: National Aboriginal Health Strategy 1989
No clearly stated relationship with:
Aboriginal and Torres Strait Islander Health Performance Framework
National Framework of Principles for Government Service Delivery to Indigenous Australians
Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework
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Aboriginal Child Placement Principle Guide
1d National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Well Being: 2004 - 2009

**Governance**

Federal, but aims to involve a broad cross-section of organisations and individuals on a national, state/territory and local/regional level.8

**ATSI involvement**

Prepared by Social Health Reference Group for National Aboriginal and Torres Strait Islander Health Council and National Melbourne Health Working Group 2004 (NSFATSIPMHSEWB, cover)

Numerous people contributed to the development of this Framework, which includes those who participated in the Social Health Reference Group and NACCHO and NACCHO affiliate consultations. Many people from Aboriginal and Torres Strait Islander organisations and other community representatives, health services and government departments contributed through written submissions, or by attending workshops. Special thanks are also due to the Writing Group that developed this Framework, which was chaired by Pat Delaney, RN, AM. The Writing Group is to be commended for its efforts to address the social and emotional well being issues raised through the consultations with practical and achievable actions (NSFATSIPMHSEWB, page 1).

**Jurisdiction**

The Framework aims to involve a broad cross-section of organisations and individuals on a national, state/territory and local/regional level.9

On a national level, the Framework includes agencies such as:

- Related government agencies and national committees in health, community services, justice, police and education portfolios.
- The National Aboriginal and Torres Strait Islander Health Council.
- Secretariat of National Aboriginal and Islander Child Care (SNAICC).
- National Aboriginal Community Controlled Health Organisation (NACCHO).
- The Aboriginal Torres Strait Islander Commission (ATSIC)

On a State/Territory level, the Framework will include:

- Framework Agreement Partners.
- Departments of health, family and community services, justice, police, education and Aboriginal and Torres Strait Islander affairs.
- NACCHO affiliates.

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On a local/regional level, the Framework will seek to involve:

- Aboriginal Community Controlled Health Services (ACCHs).
- Schools.
- Local communities, individuals and families including elders.
- General Practitioners.
- Aboriginal Health Workers.
- Aboriginal Child Care Agencies.
- Other service providers in child care, education and health.
- Child and youth mental health services.
- Recreational organisations.¹⁰

**Longevity**
2004 - 2009

**Level of impact**
A National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Well Being 2004-2009 is a five year plan to guide the work of the many agencies, both government and non-government, that work towards improving the mental health and social and emotional well being of Aboriginal and Torres Strait Islander peoples.¹¹

The Framework has been endorsed by Commonwealth and State/Territory Governments and represents agreement among a wide range of stakeholders on the broad strategies that need to be pursued. It thus provides a common ground and a basis for cooperation among responsible agencies, which include a range of Commonwealth portfolios, State Government agencies, local government, and non-government service providers.¹²

**Relationship to other instruments**
This Framework sits within the implementation processes for two documents:

- The National Strategic Framework for Aboriginal and Torres Strait Islander Health (NATSIHC, 2003-2013) provides for a whole-of-government response to health issues, including a particular focus on social and emotional well being;
  
  The National Strategic Framework for Aboriginal and Torres Strait Islander Health’s focus on cross-sectoral action builds on the existing structures provided

by Aboriginal and Torres Strait Islander organisations, including, but not limited
to, ATSIC, Link Up family reunion services, Aboriginal Child Care Agencies and
the Torres Strait Islander Advisory Board. Efforts to coordinate activities across
programs and levels of government in areas such as the Shared Future Shared
Responsibility trials, suicide prevention, substance misuse, and early childhood
development and education also provide important links. (NSFATSIPMHSEWB, page 4)

• The National Mental Health Plan 2003-2008 (NMHWG, 2003) provides a framework
for national action to improve mental health care over the next five years, including
increased access to services for Aboriginal and Torres Strait Islander peoples.
(NSFATSIPMHSEWB, page 4)

It is to be implemented within the collaborative planning processes provided by the
Aboriginal and Torres Strait Islander Health Framework Agreements signed by the
Australian Government, State or Territory Governments, ATSIC and the NACCHO
affiliate in each State and Territory, and by the Torres Strait Regional Authority in the
Torres Strait. (NSFATSIPMHSEWB, page 4)

The National Aboriginal Health Strategy (NAHSWG, 1989) and Ways Forward (Swan
and Raphael, 1995) provide the background and principles for this work.
(NSFATSIPMHSEWB, page 4)

This Framework builds on the work of a number of key reports over the past two
decades that have informed policy development for promoting social and emotional well
being for Aboriginal and Torres Strait Islander people, including:
• The National Consultancy Report on Aboriginal and Torres Strait Islander Mental
Health, ‘Ways Forward’ (1995), which was the first national analysis of Aboriginal
and Torres Strait Islander mental health.
  o The nine guiding principles have been extracted from this report (See Appendix
   6)
• The Aboriginal and Torres Strait Islander Emotional and Social Well Being (Mental
Health) Action Plan (1996-2000), which was developed to address the critical issues
outlined in Ways Forward.
• The Evaluation of the Aboriginal and Torres Strait Islander Emotional and Social
Well Being (Mental Health) Action Plan (2001), which among other things,
recommended the development of a national strategic framework
(NSFATSIPMHSEWB, page 1).
Aim
This Social and Emotional Well Being Framework is based on the Aboriginal definition of health (NAHS, 1989) recognising that achieving optimal conditions for health and well being requires a holistic and whole-of-life view of health, referring to the social, emotional and cultural well being of the whole community (NSFATSIPMHSEWB, page 2).

Purpose
The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being: 2004 – 2009 aims to 'respond to the high incidence of social and emotional well being problems and mental ill health, by providing a framework for national action' (NSFATSIPMHSEWB, page 1).

The Framework is designed to work in conjunction with the National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013 (NSFATSIH), which builds upon the Framework Agreements on Aboriginal and Torres Strait Islander Health.¹³

Rationale
This Framework aims to respond to the high incidence of social and emotional well being problems and mental ill health, by providing a framework for national action (NSFATSIPMHSEWB, page 1).

Outcomes
Has specific list of actions, how progress will be measured and who is to be involved or responsible.

Key points/aspects
The Framework contains the following five key strategic directions:
1. Focus on children, young people, families and communities.
   1.1 Strengthening families to raise healthy, resilient infants, children, and young people.
   1.2 Recognising and promoting Aboriginal and Torres Strait Islander philosophies on holistic health and healing.
   1.3 Responding to grief, loss, trauma and anger.

2. Strengthen Aboriginal Community Controlled Health Services.
   2.1 Building a skilled and confident workforce able to provide mental health and social and emotional well being services within the Aboriginal Community Controlled Health Sector.

3. Improved access and responsiveness of mental health care.
   3.1 Facilitating improved access and responsiveness of mainstream mental health care for Aboriginal and Torres Strait Islander people.

4. Coordination of resources, programs, initiatives and planning.
   4.1 Providing optimal funding and coordination in order to improve Aboriginal and Torres Strait Islander mental health and social and emotional well being.
   4.2 Improving coordination, planning and monitoring mechanisms.

5. Improve quality, data and research.
   5.1 Developing and publishing culturally appropriate data and research that reflects Aboriginal and Torres Strait Islander mental health and social and emotional well being issues and that underpin improved service delivery (NSFATSIPMHSEWB, page 15).

Implementation

Roles, responsibilities and timeframes for implementation within the context of the National Strategic Framework for Aboriginal and Torres Strait Islander Health (National Aboriginal and Torres Strait Islander Health Council, 2003) the National Mental Health Plan 2003-2008 (NMHWG 2003), and the Framework Agreement planning processes (NSFATSIPMHSEWB, page 5).

At the national level it proposes a small Social and Emotional Well Being National Advisory Group to oversight implementation and monitoring. It also sets in place improved arrangements for communication between the Australian Health Ministers Advisory Council's national committees responsible for Aboriginal and Torres Strait Islander Health (Standing Committee for Aboriginal and Torres Strait Islander Health) and for mental health (National Mental Health Working Group) (NSFATSIPMHSEWB, page 5).

Each jurisdiction is to develop its own implementation plan for the National Strategic Framework for Aboriginal and Torres Strait Islander Health. At the State and Territory level this Social and Emotional Well Being Framework provides for the development and implementation of social and emotional well being components of these implementation plans. To do this, mental health planners and Aboriginal and Torres Strait Islander Health Framework Agreement forums are to work together to ensure inclusion of key priorities from this Framework, the National Mental Health Plan 2003-2008, and existing State or Territory social and emotional well being plans (NSFATSIPMHSEWB, page 5).

At the local and regional level this Framework is to build on existing local and regional partnerships, or develop new implementation groups of service providers, to enhance
coordination between Aboriginal Community Controlled Health Services, other primary health care providers, General Practitioners, mental health services and substance misuse services (NSFATSIPMHSEWB, page 5).

A complementary implementation plan will be developed for the Torres Strait, and Torres Strait Islanders on the mainland will be consulted in the development of jurisdiction level responses (NSFATSIPMHSEWB, page 5).

**Review processes**
It is intended that oversight of its implementation and overall monitoring and reporting will be undertaken through the overall monitoring process being established by AHMAC for a whole of health system approach to implementing the NSFATSIH (NSFATSIPMHSEWB, page 1).

**Outcomes to date**
No outcomes data found using basic web search. Plan runs until 2009.

**Amount of money allocated**
Not specified.
No clearly stated relationship with:
Aboriginal and Torres Strait Islander Health Performance Framework
National Framework of Principles for Government Service Delivery to Indigenous Australians
National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being: 2004 – 2009
Framework for Reporting on Indigenous Disadvantage
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Aboriginal Child Placement Principle Guide
1e Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework

Governance
- Office for Aboriginal and Torres Strait Islander Health
- Department of Health and Ageing

ATSI involvement
The Aboriginal and Torres Strait Islander Health Workforce Working Group (ATSIHWWG) is charged with the planning, implementation, coordination and monitoring of the Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework.\(^\text{14}\)

Jurisdiction
This Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework (Workforce Strategic Framework) has been drafted as a framework for workforce reform and consolidation requiring collaboration between Commonwealth, State and Territory governments and the Aboriginal and Torres Strait Islander community controlled health sector (ATSIHWNSF, page 1).

The strategies that form part of this framework encompass both joint actions and responsibilities specific to either the Commonwealth or State and Territory governments (ATSIHWNSF, page 4).

Longevity
May 2002.

Level of impact
The Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework guides state, territory and Commonwealth government and non-government work towards enhancing the health workforce to meet the health needs of Aboriginal and Torres Strait Islander people. The Framework was endorsed by the Australian Health Ministers Advisory Council (AHMAC) in May 2002.\(^\text{15}\)

Relationship to other instruments
This Workforce Strategic Framework has been developed by the Commonwealth, State and Territory government Standing Committee on Aboriginal and Torres Strait Islander

Health (SCATSIH) for endorsement by the Australian Health Ministers’ Advisory Committee (AHMAC) (ATSIHWNSF, page 1).

It is intended that the objectives and strategies outlined in this document will be incorporated in the broader National Strategic Framework for Aboriginal and Torres Strait Islander Health which is being drafted by the National Aboriginal and Torres Strait Islander Health Council for signature by all Health Ministers. This will ensure there is alignment of the key policy frameworks for collaborative effort to improve Aboriginal and Torres Strait Islander health. (ATSIHWNSF, page 1)

This Workforce Strategic Framework is based on a commitment to nine principles as outlined in the National Strategic Framework for Aboriginal and Torres Strait Islander Health. These principles are necessary for sustained improvement in Aboriginal and Torres Strait Islander health into the 21st Century. The principles are consistent with the 1989 National Aboriginal Health Strategy (NAHS) (ATSIHWNSF, page 2).

This Workforce Strategic Framework builds upon a number of previous reviews to propose a comprehensive reform agenda. The strategies that form part of this framework encompass both joint actions and responsibilities specific to either the Commonwealth or State and Territory governments. The main reviews on which this Workforce Strategic Framework is based are:

- The National Review of Aboriginal and Torres Strait Islander Health Worker Training, synthesising a related set of reviews in each State and Territory of Aboriginal and Torres Strait Islander Health Worker Training; and
- . Estimation of Requirements for and Supply of the Health Workforce for Aboriginal and Torres Strait Islander Peoples.

As well as these two reviews there have been a number of other relevant national reviews including:

- Report of the Evaluation of Health Services Management Training for Aboriginal and Torres Strait Islander People;
- . Evaluation of the Management Support Program for Aboriginal Community Controlled Health Services;
- Strategic Framework for the Inclusion of Indigenous Health in Core Medical Curricula & Recruitment, Retention and Support Strategies for Indigenous Australians in Medical Education; and
- Evaluation of Recruitment and Promotion Services Project (ATSIHWNSF, page 4).
Aim
To transform and consolidate the workforce in Aboriginal and Torres Strait Islander health to achieve a competent health workforce with appropriate clinical, management, community development and cultural skills to address the health needs of Aboriginal and Torres Strait Islander peoples supported by appropriate training, supply, recruitment and retention strategies (ATSIHWNSF, page 3).

Rationale
This Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework (Workforce Strategic Framework) has been drafted as a framework for workforce reform and consolidation requiring collaboration between Commonwealth, State and Territory governments and the Aboriginal and Torres Strait Islander community controlled health sector (ATSIHWNSF, page 1).

It recognises that action is now required on specific strategies to improve the training, supply, recruitment and retention of appropriately skilled health professionals, health service managers and health policy officers in both mainstream and Aboriginal and Torres Strait Islander specific services. Coordination of effort is required across the Commonwealth, State and Territory governments through both health and education and training portfolios, and in partnership with training providers, mainstream and community controlled health providers to ensure the right skill mix and distribution in the health workforce and to ensure that health system reform is achievable (ATSIHWNSF, page 1).

Outcomes
A competent health workforce requires that the workforce be transformed and consolidated to:

- Increase the number of Aboriginal and Torres Strait Islander people working across all the health professions;
- Improve the clarity of roles, regulation and recognition of Aboriginal and Torres Strait Islander Health Workers as a key component of the health workforce, and improve vocational education and training sector support for training for Aboriginal and Torres Strait Islander Health Workers;
- Address the role and development needs of other health workforce groups contributing to Aboriginal and Torres Strait Islander health;
- Improve the effectiveness of training, recruitment and retention measures targeting both non-Indigenous Australian and Indigenous Australian health staff working within Aboriginal primary health services; and
- Include clear accountability for government programs to quantify and achieve these objectives and support for Aboriginal and Torres Strait Islander organisations and people to drive the process (ATSIHWNSF, page 6).

**Key points/aspects**

Objective 1 - Increase the number of Aboriginal and Torres Strait Islander people working across all the health professions. (more details about Objective 1: ATSIHWNSF, page 6)

Objective 2 - Improve the clarity of roles, regulation and recognition of Aboriginal and Torres Strait Islander Health Workers as a key component of the health workforce, and improve vocational education and training sector support for training for Aboriginal and Torres Strait Islander Health Workers. (more details about Objective 2: ATSIHWNSF, page 8)

Objective 3 - Address the role and development needs of other health workforce groups contributing to Aboriginal and Torres Strait Islander health. (more details about Objective 3: ATSIHWNSF, page 11)

Objective 4 - Improve the effectiveness of training, recruitment and retention measures targeting both non-Indigenous Australian and Indigenous Australian health staff working within Aboriginal primary health services. (more details about Objective 4: ATSIHWNSF, page 14)

Objective 5 - Include clear accountability for government programs to quantify and achieve these objectives and support for Aboriginal and Torres Strait Islander organisations and people to drive the process. (more details about Objective 5: ATSIHWNSF, page 16) (ATSIHWNSF, page 3).

**Implementation**

The National Aboriginal and Torres Strait Islander Health Council (NATSIHC) will oversee the implementation of the whole Workforce Strategic Framework and will have a role in considering the annual reports on implementation of the strategies prior to referral to SCATSIH and AHMAC. (ATSIHWNSF, page 5).

The Workforce Strategic Framework will be implemented at two levels. Firstly, the implementation of national level strategies will be auspiced through the AHMAC Aboriginal health workforce working group. This group will be a chaired by a member of
AHMAC and will comprise members from the Australian Health Workforce Officials Committee (AHWOC), the AHMAC Standing Committee on Aboriginal and Torres Strait Islander Health (SCATSIH), the Commonwealth Department of Education, Science and Training, and the National Aboriginal Community Controlled Health Organisation (NACCHO). (ATSIHWSNF, page 5).

Secondly, the Workforce Strategic Framework will be implemented at the State and Territory level through implementation plans developed under the auspices of the State and Territory Health Forums established under the Framework Agreements. The Framework Agreements operate in every State and Territory and the Torres Strait and have been developed between the Commonwealth Government, the State or Territory Government, ATSIC (or the Torres Strait Regional Authority (TSRA) in the Torres Strait Agreement) and the State or Territory affiliate of NACCHO. (ATSIHWSNF, page 5).

The State and Territory implementation plans will set out actions and agreed timeframes for the strategies in the Workforce Strategic Framework. Negotiation and agreement on these plans will occur at the State and Territory level and will be forwarded to the Aboriginal health workforce working group, and to SCATSIH and AHMAC for noting. (ATSIHWSNF, page 5).

The State and Territory implementation plans will support better coordination across sectors beyond health and human and community services, particularly into the education and training sectors (ATSIHWSNF, page 5).

**Review processes**
Not specified.

**Outcomes to date**
No outcomes data found using basic web search.

**Amount of money allocated**
Not specified.
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1 Policies and Frameworks – National
11 Framework for Reporting on Indigenous Disadvantage
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Aboriginal Child Placement Principle Guide
1f Framework for Reporting on Indigenous Disadvantage

Governance
COAG initiative

ATSI involvement
The Steering Committee has consulted widely with Indigenous organisations, governments and researchers in developing the report and the indicator framework on which it was based. The Steering Committee published consultation reports in 2003 and 2006.16

Indigenous organisations and communities made an important contribution to the feedback received. The consultation team, led by Productivity Commissioner Robert Fitzgerald, visited Indigenous communities throughout Australia — from Cape York to Tasmania; from Murdi Paaki in New South Wales, to Warburton in the Great Western Desert. The insights gained from Aboriginal and Torres Strait Islander people will be reflected in the next report, to be published in June 2007. (FROID 2006, page iii)

The consultation team also met with government agencies and senior officials from each State and Territory and the Commonwealth. In addition, meetings were held with the Ministerial Council for Aboriginal and Torres Strait Islander Affairs and, in many jurisdictions, with the relevant minister. In the process, we learned how each jurisdiction is embedding the reporting framework into policy development, implementation and evaluation. Consultations were also held with a number of academics and non-government organisations involved in Indigenous research or service delivery. Their expert advice will further inform the selection and presentation of information in the 2007 report. (FROID 2006, page iii)

Jurisdiction
In April 2002, the Council of Australian Governments commissioned the Steering Committee to produce a regular report against key indicators of Indigenous disadvantage. This report has an important long-term objective. It is to inform Australian governments about whether policy programs and interventions are achieving positive outcomes for Indigenous people. This will help guide where further work is needed. The latest edition of the report, Overcoming Indigenous Disadvantage: Key Indicators 2007, was released on 1 June 2007. Previous editions were published in 2003 and 2005.17

Longevity
2002 – present

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The first Overcoming Indigenous Disadvantage Report was released in November 2003 (FROID 2007, page 6).

**Level of impact**
Is framework for reporting on Indigenous Disadvantage.

**Relationship to other instruments**
Key Indicator Reports
- Overcoming Indigenous Disadvantage: Key Indicators 2007
- Overcoming Indigenous Disadvantage: Key Indicators 2005
- Overcoming Indigenous Disadvantage: Key Indicators 2003
Consultation Reports

**Aim**
The key task of the Overcoming Indigenous Disadvantage: Key Indicators report: to publish indicators that are relevant to both governments and Indigenous stakeholders, and that can demonstrate the impact of programme and policy interventions. Whilst there are potentially dozens of indicators, the Report is deliberately limited to a few significant indicators that best tell the story of what is happening across Australia (FROID 2006, page 7).

**Rationale**
In April 2002, the Council of Australian Governments commissioned the Steering Committee to produce a regular report against key indicators of Indigenous disadvantage. (FROID 2007, page 3).

This report has an important long-term objective. It is to inform Australian governments about whether policy programs and interventions are achieving positive outcomes for Indigenous people. This will help guide where further work is needed.\(^{18}\)

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,

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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 (OID Key Indicators 2007, page 5).

Outcomes
Key indicator reports:
Overcoming Indigenous Disadvantage: Key Indicators 2007
Overcoming Indigenous Disadvantage: Key Indicators 2005
Overcoming Indigenous Disadvantage: Key Indicators 2003

Key points/aspects
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 (OID Key Indicators 2007, page 12).

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
(OID Key Indicators 2007, page 12)

Implementation
Key indicator reports:
Review processes
A Report on Consultations undertaken on the framework for reporting on Indigenous disadvantage was released on 1 March 2007. 19
In April 2002, the council of Australian Governments (COAG) commissioned the Review of Government Service Provision to prepare a regular report on key indicators of indigenous disadvantage. Editions of the Overcoming Indigenous Disadvantage: Key Indicators were released in 2003 and 2005. 20
In 2006, the Steering Committee for the Review undertook broad consultations on the framework for reporting on Indigenous disadvantage. Consultations were held across Australia with Indigenous leaders, organisations and communities, as well as governments, service providers and expert bodies. The Report on Consultations records the comments and suggestions of those consulted. 21
The next Overcoming Indigenous Disadvantage: Key Indicators report is due out in June 2007. 22
Overcoming Indigenous Disadvantage is an ‘evolving’ report. Each edition is shaped and informed by feedback received, and updated as new evidence and data emerges. This Consultation Report provides a summary of suggestions and comments on the 2005 report, received during consultations conducted between February and August 2006 (FROID 2006, page iii).

Outcomes to date
While there was some scepticism amongst those consulted about the strength of government commitment, there was general support for governments reporting progress in overcoming Indigenous disadvantage according to the framework. Many Indigenous organisations recognised the value of the Report as an information source and advocacy tool. Some also suggested ways to improve the Report’s usefulness (FROID 2006, page 7). See 2006 report for recommendations for improvement.

Amount of money allocated
Not specified.

Cultural Respect Framework for Aboriginal and Torres Strait Islander Health

Guided by principles of: National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003 - 2013

Guided by principles of: Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework

Principles guide: Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005 - 2008

Relationship stated but unclear: National Aboriginal Health Strategy 1989

Implementation through this plan/strategy: Victorian Indigenous Affairs Framework - Improving the lives of Indigenous Victorians
No clearly stated relationship with:
Aboriginal and Torres Strait Islander Health Performance Framework
National Framework of Principles for Government Service Delivery to Indigenous Australians
National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being: 2004 – 2009
Framework for Reporting on Indigenous Disadvantage
Good practice framework. Policing illicit drugs in rural and remote Aboriginal and Torres Strait Islander communities
A National Framework for improving the health and wellbeing of Aboriginal and Torres Strait Islander Males
Be active Australia: a framework for health sector action for physical activity 2005-2010.
National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan 2000 – 2010
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A Plan for Action 2005 - 2007 Promoting Mental Health and Wellbeing
Strong Culture, Strong Peoples, Strong Families: towards a safer future for Indigenous families and communities 10 year plan
Aboriginal Child Placement Principle Guide
1g Cultural Respect Framework for Aboriginal and Torres Strait Islander Health

Governance
Commissioned by the Australian Health Ministers Advisory Council as a guiding principle in policy construction and service delivery (CRFATSIH 2004, page 3).

The Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004-2009 (the ‘Framework’) was developed by a working group of the Standing Committee on Aboriginal and Torres Strait Islander Health (SCATSIH) comprising representatives from the Northern Territory, Queensland and South Australia (CRFATSIH 2004, page 3).

ATSI involvement
Widespread consultation has occurred in the development of the Cultural Respect Framework for Aboriginal and Torres Strait Islander Health, with an early focus on agreement to the concept and definition of “Cultural Respect” (CRFATSIH 2004, page 3).

Jurisdiction
The Cultural Respect Framework is endorsed by AHMAC as an important step in a nationally consistent approach to building a culturally equipped health system that will improve access and responsiveness for Aboriginal and Torres Strait Islander peoples to mainstream services (CRFATSIH 2004, page 13).

Longevity

Level of impact
Guiding.

Relationship to other instruments
National Strategic Framework for Aboriginal and Torres Strait Islander Health, 2003
- recognition of the importance for the Cultural Respect Framework to link with key documents, including the NSFATSIH (CRFATSIH 2004, page 3)
- Recognises the principles which are consistent with this Framework (CRFATSIH 2004, page 8).

Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework, 2002
• recognition of the importance for the Cultural Respect Framework to link with this document (CRFATSIIH 2004, page 3).
• Recognises the principles which are consistent with this Framework (CRFATSIIH 2004, page 8).

The Cultural Respect Framework does not replicate, replace, or supersede existing key national strategies such as:
• the National Aboriginal and Torres Strait Islander Health Strategy, 1989;
• the National Strategic Framework for Aboriginal and Torres Strait Islander Health, 2003 - 2013; or
• the Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework, May 2002.
(CRFATSIIH 2004, page 7)

The Cultural Respect Framework also recognises the significance of the recommendations in other major reports focused on the health and wellbeing of Aboriginal and Torres Strait Islander peoples including:
• the Royal Commission into Aboriginal Deaths in Custody;
• Ways Forward, the report on the National Consultancy on Aboriginal and Torres Strait Islander Mental Health;
• Bringing them home, a report on the National Inquiry into the separation of Aboriginal and Torres Strait Islander children from their families; and
• Health Is Life: Report on Inquiry into Aboriginal and Torres Strait Islander Health, House of Representatives Canberra
(CRFATSIIH 2004, page 7)

Aim
The Cultural Respect Framework for Aboriginal and Torres Strait Islander Health aims to influence the corporate health governance, organisational management and delivery of the Australian health care system to adjust policies and practices to be culturally respectful and thereby contribute to improved health outcomes for Aboriginal and Torres Strait Islander peoples (CRFATSIIH 2004, page 8).

The Cultural Respect Framework is not another tool for building cross-cultural competency. It is an overarching framework that recognises that a concerted effort across a number of dimensions is required to systematically lift the cultural competency of mainstream health services. The challenges of today are around systematic action, value-adding and lifting the bar (CRFATSIIH 2004, page 9).
Rationale
The Cultural Respect Framework has been developed as a guiding principle in policy construction and service delivery for utilisation by jurisdictions as they implement initiatives to address their own needs, in particular mechanisms to strengthen relationships between the health care system and Aboriginal and Torres Strait Islander peoples (CRFATSIH 2004, page 3).

The Framework aims to improve relationships between the health care system and Aboriginal and Torres Strait Islander Peoples by providing a tool in policy-making and service delivery for the use of Commonwealth and State governments.23

The Cultural Respect Framework recognises that it is important to have strategies and initiatives across the range of dimensions.

- Knowledge and Awareness
- Skilled Practice and Behaviour
- Strong (Customer and Community) Relationships
- Equity of Outcomes

(for more detail about each dimension please see original document) (CRFATSIH 2004, page 10-11).

Outcomes
It is not the intention to mandate the content of an action agenda. Each jurisdiction will need to have some auditing and planning process around Cultural Respect and guidelines that may be useful in this context can be found in attachment one. The challenges and priorities will be different in each of the jurisdictions and it is important to maintain the focus on outcomes at the national level. At the same time, it is the intention of AHMAC to regularly appraise itself of the developments at the jurisdictional level and provide the whole-of-system leadership that reflects its own commitment to Cultural Respect (CRFATSIH 2004, page 18).

Key points/aspects
Cultural Respect is the:

recognition, protection and continued advancement of the inherent rights, cultures and traditions of Aboriginal and Torres Strait Islander Peoples. (emphasis in original) (CRFATSIH 2004, page 7)

Cultural Respect is about shared respect. Cultural Respect is achieved when the health system is a safe environment for Aboriginal and Torres Strait Islander peoples and where cultural differences are respected. It is a commitment to the principle that the construct and provision of services offered by the Australian health care system will not unwittingly compromise the legitimate cultural rights, practices, values and expectations of Aboriginal and Torres Strait Islander peoples. The goal of Cultural Respect is to uphold the rights of Aboriginal and Torres Strait Islander peoples to maintain, protect and develop their culture and achieve equitable health outcomes (CRFATSIH 2004, page 7).

**Implementation**
The Framework is endorsed by AHMAC, the peak administrative body in the Australian health system. However, each jurisdiction will be responsible for implementing its own processes. AHMAC will have a role in overseeing developments and providing leadership.24

AHMAC is also keen to foster on-going collaboration and sharing of information, ideas and practical strategies between jurisdictions as a key plank of continuous improvement. AHMAC will, through SCATSIH, consider establishing a national clearinghouse to facilitate that approach (CRFATSIH 2004, page 18).

There is an initial five-year commitment by AHMAC to the Cultural Respect Framework and each jurisdiction will be required to report to the joint SCATSIH/AHMAC meeting in each of those years commencing in 2004 (CRFATSIH 2004, page 18).

The focus for 2004 will be on each of the State, Territory and Commonwealth governments committing to preparing a position statement on the strengths and challenges for their jurisdiction. SCATSIH will consider and recommend a format for the annual reports. SCATSIH will also be considering and recommending ways in which AHMAC could progress the development of national standards for cultural competence (CRFATSIH 2004, page 18).

**Review processes**
Each jurisdiction will need to have some auditing and planning process around Cultural Respect and guidelines that may be useful in this context can be found in attachment one (CRFATSIH 2004, page 18).

There are already reporting mechanisms that are clearly linked to the Cultural Respect Framework such as the framework agreements that underpin partnerships at the State

level and the National Aboriginal Performance Indicators and Targets reported on annually by the State, Territory and Commonwealth governments. It is not the intention to duplicate these reports but more to supplement them with feedback from jurisdictions on their achievements and challenges in responding to the Cultural Respect Framework (CRFATSIH 2004, page 18).

AHMAC is also keen to foster on-going collaboration and sharing of information, ideas and practical strategies between jurisdictions as a key plank of continuous improvement. AHMAC will, through SCATSIH, consider establishing a national clearinghouse to facilitate that approach (CRFATSIH 2004, page 18).

There is an initial five-year commitment by AHMAC to the Cultural Respect Framework and each jurisdiction will be required to report to the joint SCATSIH/AHMAC meeting in each of those years commencing in 2004 (CRFATSIH 2004, page 18).

**Outcomes to date**

Two jurisdictions have developed their own policies in response to the National Framework:

- South Australia Health, Aboriginal Cultural Respect Framework for South Australia.25

In addition, the Victorian Department of Human Services (DHS) has endorsed a plan, consistent with the Framework, giving approval to the ongoing provision of funds for cultural respect training aimed at departmental and sector staff. The Koorie Heritage Trust was engaged by the Department to develop a program to be offered 'as a priority to departmental and sector staff whose job brings them in regular contact with Aboriginal individuals and communities' (Victorian DHS Website).26

**Amount of money allocated**

Not specified.


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<td>Implementation through this plan/strategy</td>
<td>Grey</td>
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<td>Builds on approaches in this document</td>
<td>Orange</td>
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<tr>
<td>Relationship stated but unclear</td>
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</table>
Good practice framework. Policing illicit drugs in rural and remote Aboriginal and Torres Strait Islander communities
No clearly stated relationship with:
National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003 – 2013
Aboriginal and Torres Strait Islander Health Performance Framework
National Framework of Principles for Government Service Delivery to Indigenous Australians
National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being: 2004 – 2009
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Aboriginal Child Placement Principle Guide
1h Good practice framework. Policing illicit drugs in rural and remote Aboriginal and Torres Strait Islander communities

**Governance**

**ATSI involvement**
Not specified.

**Jurisdiction**
The advice in this guide is intended for police and police organisations looking to review their approaches to policing illicit drug use and reducing drug-related harms among Aboriginal and Torres Strait Islander people in rural and remote areas (NDLERF 2006, page 1).

**Longevity**
2006 - ?

**Level of impact**
Guiding.

**Relationship to other instruments**

**National Drug Strategy**
The policing approaches used at each level must also be consistent with Australia’s National Drug Strategy, which sets the context for policing illicit drug use and efforts to reduce drug-related harms. The strategy is a comprehensive framework that requires all sectors and jurisdictions to commit to an integrated approach to drug control (NDLERF 2006, page 2).

The National Drug Strategy’s *Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003-2006* calls for all sectors, including law enforcement, in all jurisdictions to apply a range of strategies to reduce illicit drug use and drug-related harms. This requires police and other services use a range of harm minimisation principles to underpin any efforts to reduce substance use and minimise substance-related harms (NDLERF 2006, page 26).

**Aim**
The advice and materials in this guide focus on opportunities to improve policing through the use of:
1. **Strategic policies and programs** requiring different sectors and jurisdictions to commit to coordinated approaches to drug control.

2. **Local, district and regional area planning** to prevent crime and promote community safety, including the reduction of illicit drug supply and use; and

3. **Individual police practices.** (Emphasis in original)

Each of these elements is distinct, yet they do interact and influence each other. Typically they work best when coordinated as part of an holistic police approach to working in partnership with Aboriginal communities and other organisations to improve police effectiveness and improve outcomes. An holistic approach based on harm minimisation is outlined in Part 4. The aim is to provide good practice materials – examples, checklists, scenarios – that can be adapted to suit particular locations and organisational and jurisdictional priorities (NDLERF 2006, page 1).

**Rationale**

The need for strategic policies and programs to address illicit drug use among Aboriginal and Torres Strait Islander people in rural and remote areas is highlighted by the issues affecting those communities. Factors that predispose disadvantaged urban communities to high levels of hazardous substance use are often more pronounced in rural and remote areas. They include poverty, unemployment, poor health, limited education, poor infrastructure, fractured family life, stretched services, disputes over resources, and other characteristics of communities under stress. Regular employment, quality education, a cohesive family environment and other protective factors – that is, the kinds of factors that encourage users to regulate their own use and plan for the future – can be in short supply in struggling remote settlements or in neighbourhoods located in or near rural and regional centres (NDLERF 2006, page 2).

**Outcomes**

Not specified.

**Key points/aspects**

*The National Drug Strategy’s Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003-2006* calls for all sectors, including law enforcement, in all jurisdictions to apply a range of strategies to reduce illicit drug use and drug-related harms. This requires police and other services use a range of *harm minimisation* principles to underpin any efforts to reduce substance use and minimise substance-related harms:

'Harm minimisation' refers to policies and programs designed to reduce drug-related harm.
The aim of this approach is to improve health, social and economic outcomes for both the community and the individual. It encompasses a wide range of strategies, including:

- supply-reduction strategies designed to disrupt the production and supply of illicit drugs;
- demand-reduction strategies designed to prevent the uptake of harmful drug use, including abstinence-oriented strategies to reduce drug use;
- strategies to provide effective treatment, follow-up and rehabilitation services to people affected by use of alcohol, tobacco and other drugs; and
- a range of targeted harm-reduction strategies designed to reduce drug-related harm for individuals and communities

(NDLERF 2006, page 26).

**Implementation**
Not specified.

**Review processes**
Not specified.

**Outcomes to date**
The aim is to provide good practice materials – examples, checklists, scenarios – that can be adapted to suit particular locations and organisational and jurisdictional priorities (NDLERF 2006, page 1).

**Amount of money allocated**
Not specified
| Guided by the principles of                  | Pink |
| Share priority areas                        | Green |
| Implementation plan of framework           | Light Blue |
| Quantitative measurement of framework       | Red |
| Implementation through this plan/strategy  | Grey |
| To be considered/included in the planning process | Purple |
| Evaluation/monitoring tool of framework     |   |
| Builds on approaches in this document       | Orange |
| Relationship stated but unclear             | Tan |
1 Policies and Frameworks – National
1.1 A National Framework for improving the health and wellbeing of Aboriginal and Torres Strait Islander Males
No clearly stated relationship with:

Aboriginal and Torres Strait Islander Health Performance Framework
National Framework of Principles for Government Service Delivery to Indigenous Australians
National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being: 2004 – 2009
Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework
Framework for Reporting on Indigenous Disadvantage
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Good practice framework. Policing illicit drugs in rural and remote Aboriginal and Torres Strait Islander communities
Be active Australia: a framework for health sector action for physical activity 2005-2010.
National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan 2000 – 2010
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National Drug Strategy Aboriginal and Torres Strait Islander Peoples' Complementary Action Plan 2003-2009
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A Plan for Action 2005 - 2007 Promoting Mental Health and Wellbeing
Strong Culture, Strong Peoples, Strong Families: towards a safer future for Indigenous families and communities 10 year plan
Aboriginal Child Placement Principle Guide
A National Framework for improving the health and wellbeing of Aboriginal and Torres Strait Islander Males

Governance
The Framework is not owned by any one institution. It is designed to provide a structure to improve Aboriginal and Torres Strait Islander male health at all levels of government in partnership with Aboriginal and Torres Strait Islander communities (NFIHWATSIM, page xiii).

ATSI involvement
The Framework is the culmination of over three years of work undertaken by the National Aboriginal and Torres Strait Islander Males Health and WellBeing Reference Committee. The Framework is a reflection of the thoughts and needs expressed in many Aboriginal and Torres Strait Islander male meetings and conferences around the country over the last decade (NFIHWATSIM, page xii).

Jurisdiction
The Framework will not be owned by any one agency. Rather, it is the responsibility of Aboriginal and Torres Strait Islander males, their families, communities, service providers, the non-government and government sectors. It needs to be positioned within the context of existing and future policies and planning so that all stakeholders at all levels can support and enhance their actions and commitments to Aboriginal and Torres Strait Islander male health within current and future efforts (NFIHWATSIM, page 32).

Longevity
Published in June 2004. It is proposed that the Framework be in place initially for a period of three years.

Level of impact
The Framework is not a policy. It is intended as a guide for planning and programs and should be an ongoing working document which is periodically reviewed (NFIHWATSIM, page ix).
The strategies for change in this Framework are examples which can be implemented in various jurisdictions under State/Territory and local frameworks (NFIHWATSIM, page ix).
Relationship to other instruments
National Strategic Framework for Aboriginal and Torres Strait Islander Health
This strategy identifies male health as an immediate priority for government action, recognising the need to incorporate Aboriginal and Torres Strait Islander male health needs into existing planning frameworks and policy responses at all levels (NFIHWATSIM, page ix).

The key areas of focus partly reflect the development of key result areas developed in the National Strategic Framework for Aboriginal and Torres Strait Islander Health (NFIHWATSIM, page 16).

Agreements on Aboriginal and Torres Strait Islander Health established in each State and Territory
The aim of the agreements is to improve Aboriginal and Torres Strait Islander health by facilitating partnership planning for better allocation of resources and greater community access to services. Partnership at the State/Territory-based level is a key mechanism for consultation on this Framework (NFIHWATSIM, page xiii).

A broad and diverse range of national and State/Territory-specific, regional and local level strategies and policies that have a bearing on improving Aboriginal and Torres Strait Islander male health are in place. Appendix A (of original document) provides a brief outline of a selection of these strategies to highlight the potential for incorporating Aboriginal and Torres Strait Islander male health and illustrate the need to complement and enhance current activity rather than position Aboriginal and Torres Strait Islander male health in isolation from these targeted health and health-related strategies (NFIHWATSIM, page 8).

Aim
The purpose of the Framework is to integrate and provide a voice for Aboriginal and Torres Strait islander male health within:

- the health system; and
- existing and proposed strategies, services and policies across the range of settings, sectors and jurisdictions (at all levels of government – local, State/Territory and Australian) (NFIHWATSIM, page xvi).

Framework aims to:
- facilitate improvements in the commitment, knowledge, interventions and practices of stakeholders at all levels for a better and longer life for all Aboriginal and Torres Strait Islander males;
facilitate Aboriginal and Torres Strait Islander male health responses within existing policy and planning structures within both the specific Aboriginal and Torres Strait Islander as well as mainstream health arena; and

provide a framework to coordinate and integrate responses to Aboriginal and Torres Strait Islander male health and wellbeing (NFIHWATSIM, page xvi).

Rationale
This Framework is designed to strengthen and facilitate change within the health system to improve Aboriginal and Torres Strait Islander male health (NFIHWATSIM, page 7).

Outcomes
Within this context, a minimum consideration of the following recommendations is desired.

Recommendation 1: All Aboriginal and Torres Strait Islander Health forums to consider and prioritise male health issues within existing and future planning processes.

Recommendation 2: All national strategies to consider the impact on Aboriginal and Torres Strait Islander male health.

Recommendation 3: In the development of new policies and programs that impact on Aboriginal and Torres Strait Islander Health, specific allocation of resources to be considered.

Recommendation 4: Workforce development initiatives to be undertaken to ensure a gender balance is achieved within the community-controlled health sector in order to increase presentations of males at medical services.

Recommendation 5: An awareness of male sexual and reproductive health issues and how they may impact on general health, wellbeing and quality of life to be included in any health promotion strategy (NFIHWATSIM, page 33).

Key points/aspects
Key areas of focus
- Partnerships and collaboration
- Integrating Aboriginal and Torres Strait Islander male health in targeted health strategies and services
- Improving access to appropriate health care
• Workforce, education and training
• Health promotion and prevention
• Developing the evidence base
• A healthier generation

The key areas of focus are not a definitive list of priorities, but rather aim to provide a point of reference for stakeholder consideration and action…The key areas of focus partly reflect the development of the National Strategic Framework for Aboriginal and Torres Strait Islander Health (NFIHWATSIM, page 16).

Each key area has objectives and strategies and illustrations/examples, see pages 16 – 31 of original document.

**Implementation**

While health status may improve over time, action is required now to instigate work that precipitates future successes. We need to build on the Framework and to include an evaluation process, so that during the initial three-year timeframe and afterwards, its relative progress can be determined (NFIHWATSIM, page 32).

**Review processes**

It is recommended that the Framework be in place in initially for a period of three years. During this time, it is important that during this time, information be exchanged on:
• improvements in Aboriginal and Torres Strait Islander male health and wellbeing;
• the acceptance, commitment and support of the Framework key stakeholders;
• progress and achievements in the key areas of focus;
• the ongoing effectiveness and sustainability of the Framework; and
• the commitment and sustainability of partnerships.

Information may be shared in a variety of ways including through:
• ongoing local/regional male health networks/groups;
• formal arrangements under the State/Territory and national level Framework Agreements; and
• web-based solutions, publications and other media (NFIHWATSIM, page 32).

**Outcomes to date**

No outcomes data found using basic web search.

**Amount of money spent/allocated**

Not specified
1 Policies and Frameworks – National

1) Be active Australia: a framework for health sector action for physical activity 2005-2010

Relationship stated but unclear: National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003 - 2013

Be active Australia: a framework for health sector action for physical activity 2005-2010.

Relationship stated but unclear: Aboriginal and Torres Strait Islander Health Performance Framework
No clearly stated relationship with:

National Framework of Principles for Government Service Delivery to Indigenous Australians
National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Well Being: 2004 – 2009
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Strong Culture, Strong Peoples, Strong Families: towards a safer future for Indigenous families and communities 10 year plan
Aboriginal Child Placement Principle Guide
1j Be active Australia: a framework for health sector action for physical activity 2005-2010.

**Governance**
Developed by The Strategic Inter-Governmental forum on Physical Activity and Health (SIGPAH) of the National Public Health Partnership. Endorsed by the Australian Health Ministers’ Conference, July 2005 (BAA 2005, page i).

**ATSI involvement**
The Actions are based on consultations with Aboriginal and Torres Strait Islander stakeholders and the general consultations for BAA, the Adelaide Workshop and other national documents (BAA 2005, page 32).

**Jurisdiction**
*Be Active Australia: A Framework for Health Sector Action for Physical Activity 2005–2010* provides a national framework for coordinated and comprehensive health sector action over the next five years. It aims to add value to the work at jurisdictional levels, as well as identifying clear links and opportunities for united approaches through other national strategies, including work on healthy weight, nutrition, chronic disease prevention, falls prevention, healthy ageing, child health and Aboriginal and Torres Strait Islander peoples’ health (BAA 2005, foreword).

**Longevity**
2005-2010

**Level of impact**
The Framework aims to increase awareness and understanding of the health and related benefits of participation in physical activity, and provide the structure that will assist individuals to develop the necessary skills that are central to a physically active and healthy lifestyle. (BAA 2005, page 1)

The Framework seeks to consolidate the current investment of government, non-government and private organisations and ensure that it is spent strategically. (BAA 2005, page 1)

**Relationship to other instruments**
The importance of physical activity in relation to different health-related conditions and issues, population groups, settings and communities makes it important for BAA to link with, and add synergy to, other national strategies and frameworks including:

- *Eat Well Australia*
• Healthy Weight 2008 – Australia’s future: the national action agenda for children and young people and their families
• Preventing Chronic Disease: A Strategic Framework
• National Injury Prevention Strategy (currently being revised) and especially falls prevention
• Plans related to National Health Priority Areas including diabetes, cardiovascular disease, cancer, injury (see above), mental health, arthritis and musculoskeletal conditions
• The National Environmental Health Strategy

The National Strategic Framework for Aboriginal and Torres Strait Islander Health outlines a clear commitment to improving the health of Aboriginal and Torres Strait Islander Australians but notes the solutions are complex requiring a ‘coordinated, collaborative and multisectoral approach’ supported by Aboriginal and Torres Strait Islander health stakeholder organisations at all levels of government. 13 The National Strategic Framework for Aboriginal and Torres Strait Islander Health Framework for Action by Governments recognises the potential health gains to be made from improving physical activity and nutrition and identifies physical activity actions. 13 BAA now provides additional detail to this Framework (BAA 2005, page 32).

There is evidence to suggest programs should be consistent with the following Key Principles: nine principles (BAA 2005, page 33).


Aim
The Framework aims to increase awareness and understanding of the health and related benefits of participation in physical activity, and provide the structure that will assist individuals to develop the necessary skills that are central to a physically active and healthy lifestyle. The determinants of physical activity are addressed, along with ways to improve public policy for physical activity, by promoting, developing and
supporting policy that facilitates and encourages physical activity for health (BAA 2005, page 1).

The Vision
All Australians enjoying the benefits of physical activity as a part of everyday life.

The Goal
To improve the health and well being of all Australians and reduce inactivity and related disease and disability by increasing levels of physical activity across the population. More specifically the intention is to ensure all Australians meet relevant National Physical Activity Guidelines (BAA 2005, page 6).

Rationale
Examples of barriers to physical activity faced by Aboriginal and Torres Strait Islanders include:

Policy: lack of funding for programs, services and infrastructure; poorly coordinated program development within health and across sectors; and, disparate approaches to strategic planning and research.

Environments: physical conditions including hot, dry, dusty or wet conditions or humidity; unsafe communities; lack of facilities and infrastructure; services and programs; dominance of cars; and, limited income.

Socio-cultural: services which are culturally inappropriate or unwelcoming; transgenerational issues which don’t support physical activity; limited role models; racism; and competing influences (television, gambling).

Psychosocial: high rates of: depression; disempowerment; sense of hopelessness; lack of motivation; lack of knowledge; and, confidence.

Individual: poor health, including sickness; excess weight; inadequate nutrition; or limiting physical conditions.

Health Services: limited time for prevention; lack of referral to sport or other physical activity programs; and, limited funding for health related physical activity programs.

Most of the actions in BAA are relevant to, and should assist in, increasing levels of physical activity by Aboriginal and Torres Strait Islander Australians. In addition, there are a number of specific recommendations throughout BAA that have been developed in response to consultations with Aboriginal and Torres Strait Islander peoples (BAA 2005, page 32).

Outcomes
A detailed plan to support physical activity for Aboriginal and Torres Strait Islander Australians including integration with other relevant strategies.

Increased support for implementation of BAA including on the ground programs (BAA 2005, page 33).
Key points/aspects
The Framework seeks to consolidate the current investment of government, non-government and private organisations and ensure that it is spent strategically. The significance of inactivity in Australia, however, warrants additional funding to that currently being invested. The Framework clearly identifies the priorities for action that require commitment if the community is to be effectively supported to achieve appropriate levels of physical activity (BAA 2005, page 1).

Priority Populations:
Aboriginal and Torres Strait Islander peoples
With the worst health status, high levels of disadvantage and a range of barriers to physical activity, BAA has a particular focus on Aboriginal and Torres Strait Islander peoples and includes specific actions throughout (BAA 2005, page 9).

Be Active Australia: A Framework for Health Sector Action for Physical Activity 2005–2010
1. Develop, in further consultation with a broad range of Aboriginal and Torres Strait Islanders, a detailed implementation plan for BAA.
2. Ensure the inclusion of physical activity into Framework Agreements being developed in all jurisdictions.
3. Develop practical strategies to assist community controlled health services and mainstream health services to encourage Aboriginal and Torres Strait Islanders to be active.
4. Consider options for providing national strategic leadership, partnerships and coordination on physical activity across government for Aboriginal and Torres Strait Islander Australians.
5. Consider options to increase funding, support and recognition for the development, implementation and evaluation of local physical activity best practice programs that are:
   • Designed, implemented and owned locally, using community development processes, and which are supported nationally;
   • Aimed at building the leadership and capacity for sustained action by individuals and the community in the area of physical activity and other issues;
   • Relevant to local issues, needs, cultures and conditions;
   • Based on, and supportive of, the knowledge, skills, experience and resources of the community;
   • Consistent with best practice principles including a holistic approach to health;
   • Focussed on overcoming barriers to physical activity for individuals and communities.
6. Actively seek opportunities to integrate physical activity into relevant national, state and local policies, programs and initiatives (in the health sector and other relevant sectors including sport and recreation, planning) particularly in relation to nutrition (NATSINSAP), healthy weight, chronic disease prevention and community development.

7. Explore the potential for partnerships with other sectors and private industry (mining, employment, sport and recreation) with a view to supporting physical activity programs and initiatives and creating broad support for physical activity as well as win/win outcomes such as income earning opportunities.

8. Support appropriate research into the barriers and facilitators of physical activity for Aboriginal and Torres Strait Islander communities (BAA 2005, page 34-35).

**Implementation**

BAA presents a framework for national action by the health sector over the coming five years. A more detailed implementation plan will be developed by SIGPAH outlining timelines, lead organisations, indicators and key milestones to inform an evaluation plan and other details (BAA, page 39).

**Review processes**

A Monitoring and Reporting Framework will also be prepared, published on the NPHP website (www.nphp.gov.au) and regularly updated to maximise accountability for implementation progress. (BAA, page 39)

BAA will be evaluated after three years to inform progress, future directions and the next stage. In addition, BAA will be distributed and promoted widely. (BAA, page 39)

**Outcomes to date**

No outcomes data found using basic web search. Plan runs until 2010.

**Amount of money allocated**

National and state governments, non-government and private sector organisations already fund a range of physical activity programs and initiatives. BAA seeks to consolidate this investment and ensure that it is spent strategically. The significance of inactivity in Australia however, warrants significant additional funding to that currently being invested. BAA clearly identifies the priorities for action that require investment and commitment, if physical activity is to be addressed in Australia. (BAA, page 3)
<table>
<thead>
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<th>Guided by the principles of</th>
<th>Pink</th>
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<tbody>
<tr>
<td>Share priority areas</td>
<td>Green</td>
</tr>
<tr>
<td>Implementation plan of framework</td>
<td>Light Blue</td>
</tr>
<tr>
<td>Quantitative measurement of framework</td>
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<tr>
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<td>To be considered/included in the planning process</td>
<td>Purple</td>
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<tr>
<td>Relationship stated but unclear</td>
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</table>
Relationship stated but unclear: Victorian Indigenous Affairs Framework - Improving the lives of Indigenous Victorians

National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan 2000 - 2010

No clearly stated relationship with:
National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003 – 2013
Aboriginal and Torres Strait Islander Health Performance Framework
National Framework of Principles for Government Service Delivery to Indigenous Australians
National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being: 2004 – 2009
Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework
Framework for Reporting on Indigenous Disadvantage
Cultural Respect Framework for Aboriginal and Torres Strait Islander Health
Good practice framework. Policing illicit drugs in rural and remote Aboriginal and Torres Strait Islander communities
A National Framework for improving the health and wellbeing of Aboriginal and Torres Strait Islander Males
Be active Australia: a framework for health sector action for physical activity 2005-2010.
Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005 – 2008
Closing the Gap between Indigenous and non-Indigenous Australians
National Drug Strategy Aboriginal and Torres Strait Islander Peoples' Complementary Action Plan 2003-2009
A Fairer Victoria 2009
A Fairer Victoria 2008: Strong People, Strong Communities
Department of Human Services Aboriginal Services Plan 2008-2010
Aboriginal Cultural Competence Framework
Because Mental Health Matters: Victorian Mental Health Reform Strategy 2009-2019
A Plan for Action 2005 - 2007 Promoting Mental Health and Wellbeing
Strong Culture, Strong Peoples, Strong Families: towards a safer future for Indigenous families and communities 10 year plan
Aboriginal Child Placement Principle Guide
2 Guidelines and strategies - National

2a National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan 2000 - 2010

Governance
The Australian Health Ministers Conference of 1 August 2001 endorsed the national public health nutrition strategy, ‘Eat Well Australia’ and its Indigenous component the ‘National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan (NATSINSAP)’, developed by the Strategic Inter-Governmental Nutrition Alliance of the National Public Health Partnership (NATSINSAP 2001, page i).

ATSI involvement
Many organisations and individuals have made valuable contributions to the development of the Strategy and Action Plan, including

- Aboriginal and Torres Strait Islander nutrition workforce;
- NACCHO; and
- ATSIC (See page 8 for complete list of who was on working party).

(NATSINSAP 2001, page 8).

Jurisdiction
The Strategy and Action Plan has a directed mandate for action from the ATSI Nutrition Working Party to improve Indigenous nutrition. Consultations for the development of this strategy also strongly support this. Central to achieving this is a sustainable management structure to direct and coordinate implementation, monitoring and evaluation over the next ten years (NATSINSAP 2001, page 19).

Longevity

Level of impact
The Strategy and Action Plan provides a framework for national action to bring about an improvement in the nutritional status of Aboriginal and Torres Strait Islanders. It is the wish of the Working Party that the strategy is read and implemented in the spirit of collaboration in which it was developed (NATSINSAP 2001, page 3).

Existing structures and formal communication mechanisms, which could play a crucial role in guiding implementation and management of the Strategy and Action Plan include:
- Framework agreements between the Commonwealth, States and Territories, ATSIC, NACCHO, State NACCHO affiliates and the Torres Strait Regional Authority. The intention of the Framework agreements is to assist cooperative planning between these agencies;
- The Strategic Inter-Governmental Nutrition Alliance (SIGNAL) which has been established as the nutrition arm of the National Public Health Partnership to further the implementation of national food and nutrition policy in Australia;
- State and territory food and nutrition policy/strategies either exclusively for or with a major focus on Aboriginal and Torres Strait Islander peoples. Mechanisms for management, commitment to implementation and coordination of these initiatives vary; and
- There are numerous locally produced and/or area specific plans within the area of nutrition and diabetes which have variable implementation protocols in place (NATSINSAP 2001, page 19).

**Relationship to other instruments**

**Eat Well Australia**
- Nutrition Strategy and Action Plan is a key component of Eat Well Australia.
- Eat Well Australia is a national framework for population based action in public health nutrition for all Australians (NATSINSAP 2001, page 8).

Existing structures which could play a crucial role include Framework Agreements between Commonwealth, States and Territories, ATSIC, NACCHO, State NACCHO Affiliates and the Torres Strait Regional Authority (NATSINSAP 2001, page 19).

**Aim**
To facilitate work relating to ATSI nutrition within the broad framework proposed for the whole of population and to link with Eat Well Australia initiatives where appropriate (NATSINSAP 2001, page 8).

**Guiding Principles**
The following core principles underpin the National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan (for more detail see pages 16-17).
1. Aboriginal and Torres Strait Islander self-determination and community-control.
2. Open consultation and an ongoing commitment to working together.
3. Aboriginal and Torres Strait Islander community and family relationships.
Supports the overarching principles and goals of the National Aboriginal Health Strategy (1989), promoting a holistic approach to health care and an Aboriginal and Torres Strait Islander definition of health.
Build on and complement existing state and territory food and nutrition policies and plans for Aboriginal and Torres Strait Islander people in addition to other key Indigenous health strategies. Improvements in the health of Aboriginal and Torres Strait Islander people will require long-term commitment and resources (NATSINSAP 2001, pp 16-17).

**Rationale**
To ensure national coordination and cooperation across the country, the Strategy and Action Plan has been designed to build on existing efforts to make healthy food choices easier choices for ATSI people, irrespective of where they live (NATSINSAP 2001, page 8).

**Outcomes**
Pages 40-44 list outcomes by Action Area and suggested dates that these could be achieved by. The timeframes are indicative only (NATSINSAP 2001, page 40-44).

**Key points/aspects**
The following action areas of the Strategy and Action Plan cover a wide range of issues. To effectively implement each of the activities the active cooperation and support of a range of other sectors is required.

- Food supply in remote and rural communities
- Food security and socioeconomic status
- Family focused nutrition promotion: resourcing programs, disseminating and communicating ‘good practice’
- Nutrition issues in urban areas
- The environment and household infrastructure
- Aboriginal and Torres Strait Islander nutrition workforce
- National food and nutrition information systems (NATSINSAP 2001, page 22).

**Implementation**
SIGNAL will need to gain the necessary agreements at NPHP and Ministerial level, and at that point the implementation, including costing, can begin (NATSINSAP 2001, page 22).

First phase activities and broad time frames (2000-2003) have been identified to assist implementation of the Strategy and Action Plan. These first phase activities are intended to serve as a guide for an Implementation Group to develop an implementation plan. It is recognised that the timeframes suggested can be indicative only and that the
actions will rely on the availability and allocation of resources (NATSINSAP 2001, page 40).

**Review processes**
The Implementation Group, together with government health departments will oversee the monitoring and evaluation of the various initiatives, and will make decisions as to the adaptations necessary. Through constant monitoring and reporting and periodic evaluation, the Implementation Group and government health departments will ensure that new opportunities are taken advantage of, that effective practice is built on and replicated, and that any initiatives that need modification are addressed (NATSINSAP 2001, page 21).

**Outcomes to date**
*National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan quarterly update, April 2008*

**Amount of money allocated**
Not specified.
Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005-2008

Guided by principles of: National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003 - 2013

To be included in the planning process: National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003 - 2013

Guided by principles of: Cultural Respect Framework for Aboriginal and Torres Strait Islander Health

To be included in the planning process: National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003 - 2013

Builds on approaches in this document: National Aboriginal Health Strategy 1989


Builds on approaches in this document: National Strategic Framework for Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework

Shares priority areas with: Department of Human Services Aboriginal Services Plan 2008-2010
No clearly stated relationship with:
Aboriginal and Torres Strait Islander Health Performance Framework
National Framework of Principles for Government Service Delivery to Indigenous Australians
National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being: 2004 – 2009
Framework for Reporting on Indigenous Disadvantage
Good practice framework. Policing illicit drugs in rural and remote Aboriginal and Torres Strait Islander communities
A National Framework for improving the health and wellbeing of Aboriginal and Torres Strait Islander Males
Be active Australia: a framework for health sector action for physical activity 2005-2010.
National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan 2000 – 2010
Closing the Gap between Indigenous and non-Indigenous Australians
Australia’s National Oral Health Plan 2004-2013
Victorian Indigenous Affairs Framework - Improving the lives of Indigenous Victorians
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Strong Culture, Strong Peoples, Strong Families: towards a safer future for Indigenous families and communities 10 year plan
Aboriginal Child Placement Principle Guide
2b Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005 – 2008

**Governance**

Australian Government, Department of Health and Ageing

Other government departments and agencies have a role to play, including:

- Department of Families and Community Services
- Immigration
- Multicultural and Indigenous Affairs
- Employment and Workplace Relations
- Education
- Science and Training
- Australian Agency for International Development (AusAID)

(ATSISHBBVS 2005, page 50).

The role of the Australian Government in relation to improving sexual health and reducing blood borne viruses in Aboriginal and Torres Strait Islander people is to:

- facilitate national policy formation
- coordinate national initiatives
- commission research into key areas of strategic relevance such as surveillance and data collection
- monitor and evaluate the strategy
- administer specific and relevant funding to state/territory governments and to ACCH’s

(ATSISHBBVS 2005, page 50).

**ATSI involvement**

Effective monitoring and evaluation will also require adequate consultation and involvement of Aboriginal Torres Strait Islander people. This will ensure Aboriginal and Torres Strait Islander ownership of data sets, which will enhance commitment to activities outlined in the Strategy (ATSISHBBVS 2005, page 56).

**Jurisdiction**

The Australian Government Department of Health and Ageing is the principal Australian agency responsible for the coordination of the national response to improve sexual health and reduce blood borne viruses in Aboriginal and Torres Strait Islander people. Other government departments and agencies have role to play in the national response to improving Aboriginal and Torres Strait Islander health outcomes and the objectives of the Strategy, including particularly: the departments of Family and Community Services;
Immigration, Multicultural and Indigenous Affairs; Employment and Workplace Relations; Education, Science and Training; and the Australian Agency for International Development (AusAID). Action in this area is influenced by the Framework Agreements and the Partnership Forums that exist in each jurisdiction. (ATSISHBBVS 2005, page 5)

A wide range of community representative groups and individuals, within and outside the health sector will continue to have an important role in the implementation of this Strategy. These include:

- Australian Federation of AIDS Organisations (AFAO);
- Scarlet Alliance;
- Australian Injecting and Illicit Drug Users League (AIVL);
- Australian Hepatitis Council;
- National Association of People Living with HIV/AIDS (NAPWA);
- Sexual Health and Family Planning Australia;
- state and territory multicultural HIV/AIDS and hepatitis C services;
- Australian National Council on Drugs (ANCD);
- local governments
- ACCHSs; and
- community members including elders, Aboriginal and Torres Strait Islander health workers, other health staff, community centres and other relevant special interest groups.

(ATSISHBBVS 2005, page 32)

**Longevity**


**Level of impact**

Action in this area is influenced by the Framework Agreements and the Partnership forums that exist in each jurisdiction (ATSISHBBVS 2005, page 29).

**Relationship to other instruments**

This Strategy is designed to build on key actions identified in the NIASHS and its Implementation Plan, and to enhance and extend activity in relation to sexual health and BBV. It is also designed to complement and build on actions identified in other related national strategies including: (see page 47-49 for more details about these strategies)


The [National Hepatitis C Strategy 2005-2008](#);

The [National STI Strategy 2005-2008](#);

The [National Strategic Framework for Aboriginal and Torres Strait Islander Health](#);
The National Drug Strategy and the National Drug Strategy: Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003-2006; The Aboriginal and Torres Strait Islander Health Workforce Strategic Framework; and Aboriginal and Torres Strait Islander Commission (ATSIC) Family Violence Strategy. It is also acknowledged that there are a number of State and Territory government-based policies that are relevant to local implementation of the Strategy (ATSISHBBVS 2005, page 47).

National Indigenous Australians’ Sexual Health Strategy (NIASHS) 1996-97 to 2003-04 NATSISHBBVS builds upon the work of the National Indigenous Australians’ Sexual Health Strategy (NIASHS) 1996-97 to 2003-04 (CoA, 1997), which provided the first comprehensive approach to preventing the spread of HIV, other STIs and blood borne viruses (BBV) in Aboriginal and Torres Strait Islander communities (ATSISHBBVS 2005, page vi).

National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013
A commitment to the nine principles in the National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013 (CoA, 2004). The principles are also recognised in the following strategies:
• Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004-2009 (AHMAC, 2004)
• Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework (SCATSIH, 2002)
• and are consistent with the National Aboriginal Health Strategy 1989 (Department of Health & Community Services, 1989).
(ATSISHBBVS 2005, page 2)

A number of other policy parameters have been identified in the National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003 - 2013 that are important for health improvement. These policy parameters must also underpin the Strategy if an effective response to improving sexual health and reducing BBV in Aboriginal and Torres Strait Islander populations is going to be achieved. They include:
• Comprehensive Primary Health Care
• Evidence-based practice and policy
• Access to appropriate care in the health mainstream sector
• Health promotion
• Australia’s approach to health promotion is set within the overall framework of the Ottowa Charter for Health Promotion (WHO, 1986),
• Harm minimization, a primary principle underpinning the National Drug Strategy;
• Harm reduction interventions/strategies.
(ATSISHBBVS 2005, pp 3-5) (more detail about each policy parameter on pages 3-5)

**Aim**
The goal of the Strategy is to:
Reduce the transmission of and morbidity caused by HIV/AIDS, STIs and BBV in the Aboriginal and Torres Strait Islander community and to minimise the social and personal impacts of these infections (ATSISHBBVS 2005, page 1).

**Objectives**
The Strategy seeks to:
• improve access to testing, diagnosis, treatment and care of HIV/AIDS, STIs and BBV for Aboriginal and Torres Strait Islander people;
• respond to Australia’s role in the prevention of a HIV epidemic in the Torres Strait region;
• improve surveillance and research activities in order to guide the development and implementation of prevention, treatment and care initiatives in the Aboriginal and Torres Strait Islander community;
• improve awareness of HIV/AIDS, STIs and BBV in the Aboriginal and Torres Strait Islander community; and
• develop and strengthen links with the related national mainstream strategies (ATSISHBBVS 2005, page 1).

**Rationale**
Within this Strategy, a number of target populations and actions have been identified. There are four areas that are considered to be of high priority. There is ample population-based and disease-based evidence that supports these priorities being given greater emphasis. The impact on Aboriginal and Torres Strait Islander communities and individuals of failure to act is potentially critical. Action to address them will require concerted effort by Indigenous-specific and mainstream health services.
The four priorities are:
• sexually transmissible infections;
• Aboriginal and Torres Strait Islander people living in the cross border region of Australia and Papua New Guinea;
• access to needle and syringe programs; and
• increased capacity in the health and community workforce to address all aspects of Aboriginal and Torres Strait Islander HIV/AIDS, STIs and BBV (ATSISHBBVS 2005, page 1).
The Strategy has been prepared in parallel with the development of the following strategies:

- The National Hepatitis C Strategy 2005-2008; and

It is important to recognise that the Strategy is intended to complement these documents and should be read in association with them. The purpose of the Strategy is not to duplicate the content of these related Strategies which do cover aspects of Aboriginal and Torres Strait Islander issues, but to highlight the additional priorities and special issues that are unique to the prevention and treatment needs of ATSI people in relation to HIV/AIS, STIs and BBV (ATSISHBBVS 2005, page vi).

**Outcomes**

Each action area has a list of Actions, however there are no timeframes associated with individual actions. Actions are on the following pages:

- Action Area One – Partnerships: page 33
- Action Area Two – Prevention: page 38
- Action Area Three – Diagnosis, Treatment, Care And Support: page 41
- Action Area Four – Workforce: page 43
- Action Area Five – Research and Surveillance: Page 46

**Key points/aspects**

Actions:

- Action Area One – Partnerships (ATSISHBBVS 2005, pp29-33)
- Action Area Two – Prevention (ATSISHBBVS 2005, pp33-38)
- Action Area Three – Diagnosis, Treatment, Care And Support (ATSISHBBVS 2005, pp38-41)
- Action Area Four – Workforce (ATSISHBBVS 2005, pp42-43)
- Action Area Five – Research and Surveillance (ATSISHBBVS 2005, pp44-46)

**Implementation**

The Ministerial Advisory Council on AIDS, Sexual Health and Hepatitis (MACASHH) and its three subcommittees will oversee this implementation process and report to the Minister for Health and Ageing on the progress of all four strategies (ATSISHBBVS 2005, page v).

An [implementation plan for the Strategy](#) will be developed by the Australian Government, with support from IASHC, in consultation with state and territory governments, jurisdictionally-based sexual health committees, and NACCHO and other
peak community organisations. This plan will be developed in line with the Aboriginal and Torres Strait Islander Health Performance Framework with specific performance measures for sexual health and BBVs (ATSISHBBVS 2005, page 56).

The implementation plan will:

- Assign clear responsibility to lead and partner agencies for particular actions;
- define key performance indicators to measure the success of the Strategy; and
- identify linkages among related implementation plans.

The implementation plan is a national document, with responsibility for its implementation shared by the Australian Government, State and Territory Governments, the community sector, the research sector and other organisations. It is specific enough to enable identification of the outcomes to be achieved, but broad enough to accommodate local differences in implementation. (ATSISHBBVS Implementation Plan, page 5).

The implementation plan assigns responsibility for action by both lead agencies and partners. For the purposes of this plan, a ‘lead’ agency has a leadership role and is responsible for initiating, coordinating and progressing action. The lead agency may not necessarily be the funding body. In some cases they may be responsible for undertaking the majority of the action. A ‘partner’ agency is responsible for assisting and supporting jurisdictional agency has whole or part responsibility for action. It should be acknowledged that a range of organisations that are not specifically identified in the plan may be involved in implementation (ATSISHBBVS Implementation Plan, page 5).

It is intended that a mid-term review of progress of implementation of the Strategy will commence in February 2007 for completion in June 2007. A final review of the implementation of the Strategy will commence in September 2008 for completion by December 2008. These processes will ensure that the response to improving Aboriginal and Torres Strait Islander peoples’ sexual health and reducing the impact of BBVs maintains its momentum, while being flexible enough to address emerging priorities. While all agencies involved in implementation share responsibility for monitoring the achievements of the Strategy, this process will be led and co-ordinated by the Department of Health and Ageing (ATSISHBBVS Implementation Plan, page 6).

At the national level, the Australian Government and State and Territory governments will report annually to Health Ministers through MACASHH, IASHC, IGCAHRD and the Partnership Forums in each jurisdiction on the implementation of the Strategy (ATSISHBBVS 2005, page 56).
Review processes
The monitoring and evaluation framework to be developed as part of the implementation plan will enable and encourage planning for data collection, evaluations of specific initiatives and identification of unmet meet. The framework will identify:

- key evaluation questions;
- data requirements;
- timing; and
- governance of the evaluation.

Responsibility for the evaluation of individual programs and initiatives remains with the jurisdiction that funds or manages the program. It will be important to ensure evaluations take place within a nationally consistent monitoring and evaluation framework (ATSISHBBVS 2005, page 58).

Monitoring activities at the national level which provide data and information on the effectiveness of activities to improve sexual health and reduce BBVs in Aboriginal and Torres Strait Islander people include:

- annual surveillance reports of the National Centre in HIV Epidemiology and Clinical Research and the National Centre for HIV Social Research;
- annual communicable diseases surveillance reports of the Communicable Diseases Network Australia;
- data from the National Notifiable Diseases Surveillance System;
- monitoring and evaluation of the Strategy’s implementation at the national level by the Office for Aboriginal and Torres Strait Islander Health and Population Health Division (Australian Government Department of Health and Ageing);
- State and Territory governments’ annual reporting on activities funded through the Australian Government’s 2003-04 Hepatitis C Education and Prevention Initiative and Public Health Outcomes Funding Agreements between the Australian Government and all State and Territory governments;
- Reporting from ACCHSs on sexual health and BBV activities and outcomes funded by OATSIH;
- Partnership Forums’ monitoring and evaluation of the Strategy’s implementation within their jurisdictions; and
- Sexual Health subcommittees within each jurisdiction providing activity reports to IASHC on the implementation of the Strategy (ATSISHBBVS 2005, page 57).

These sources of data have the potential to link into a systematic framework which maps and evaluates the work done at all levels, as recommended by the Joint United Nations Program on HIV/AIDS (UNAIDS) 2000:
<table>
<thead>
<tr>
<th>Level</th>
<th>Sources of Data</th>
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</thead>
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<tr>
<td>Health Impact</td>
<td>State and National Surveillance Data</td>
</tr>
<tr>
<td>Health Outcomes</td>
<td>State and National Behavioural Research Data</td>
</tr>
<tr>
<td>Outputs</td>
<td>Jurisdiction and program reports</td>
</tr>
<tr>
<td>Inputs</td>
<td>Jurisdiction and program reports</td>
</tr>
</tbody>
</table>

(ATSISHBBVS 2005, page 57)

**Outcomes to date**
No outcomes data found using a basic web search.

**Amount of money allocated**
Not specified.
No clearly stated relationship with:

- National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003 – 2013
- Aboriginal and Torres Strait Islander Health Performance Framework
- National Framework of Principles for Government Service Delivery to Indigenous Australians
- National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being: 2004 – 2009
- Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework
- Framework for Reporting on Indigenous Disadvantage
- Cultural Respect Framework for Aboriginal and Torres Strait Islander Health
- Good practice framework. Policing illicit drugs in rural and remote Aboriginal and Torres Strait Islander communities
- A National Framework for improving the health and wellbeing of Aboriginal and Torres Strait Islander Males
- National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan 2000 – 2010
- Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005 – 2008
- Australia's National Oral Health Plan 2004-2013
- Victorian Indigenous Affairs Framework - Improving the lives of Indigenous Victorians
- A Fairer Victoria 2008: Strong People, Strong Communities
- Department of Human Services Aboriginal Services Plan 2008-2010
- Aboriginal Cultural Competence Framework
- Because Mental Health Matters: Victorian Mental Health Reform Strategy 2009-2019
- Strong Culture, Strong Peoples, Strong Families: towards a safer future for Indigenous families and communities 10 year plan
- Aboriginal Child Placement Principle Guide
2c Closing the Gap between Indigenous and non-Indigenous Australians

**Governance**
Federal Government budget statement.

**ATSI involvement**
Our ‘closing the gap’ commitments require effective engagement with Aboriginal and Torres Strait Islander people at all levels. Government needs to involve Indigenous people in the design and delivery of programs locally and regionally, and share responsibility for outcomes. Solutions developed on the ground must be driven by the communities that will ultimately determine their success or failure (Closing the Gap 2008, page 5).

The Government went to the election with a commitment to set up a national representative body to provide an Aboriginal and Torres Strait Islander voice within government. We will soon begin formal discussions with Indigenous people about the role, status and composition of this body (Closing the Gap 2008, page 5).

**Jurisdiction**
It will require sustained action across all levels of government, all sectors and the length and breadth of the country. Governments, Indigenous people and the private sector must work together if we are to make inroads (Closing the Gap 2008, page 1).

The Australian Government's commitment to turn around Indigenous disadvantage is supported by $425.3 million in new funds in the 2008-09 Budget (see Appendix 2). The funding is provided across eight portfolios, but will be spent as part of an integrated whole-of-government strategy (Closing the Gap 2008, page 1).

**Longevity**
2008.

**Level of impact**
The Close the Gap Indigenous Health Equality Summit was held 18-20 March 2008 in Canberra and was convened by the Aboriginal and Torres Strait Islander Social Justice Commissioner, Tom Calma.

Attended by more than 100 professionals from both Aboriginal and mainstream health bodies, the summit focused on targets and a plan of action to address the 17-year life expectancy gap between Aboriginal and non-Aboriginal Australians within a generation (DHS Aboriginal Services Plan 2008, page 42).
The summit culminated with the signing of a Statement of Intent, highlighting the commitment of the Commonwealth Government and peak Aboriginal organisations to work together to achieve equality in health status and life expectancy between Aboriginal and Torres Strait Islander peoples and non-Aboriginal Australians by the year 2030 (DHS Aboriginal Services Plan 2008, page 42).

**Relationship to other instruments**
The Australian Government also recognises the importance of the [United Nations’ Declaration on the Rights of Indigenous Peoples](#). Detailed consultations are currently being undertaken with Australia’s State and Territory governments as well as with Aboriginal and Torres Strait Islander organisations and other key stakeholders on the Declaration (Closing the Gap 2008, page 5).

**Aim**
The Australian Government’s reform agenda — both in Aboriginal and Torres Strait Islander affairs and across governments — is to address the structural and systemic problems that are producing appalling outcomes for Aboriginal and Torres Strait Islander people (Closing the Gap 2008, page 3).

**Rationale**
There are just over half a million Aboriginal and Torres Strait Islander people in Australia today. There is an unacceptable gap in living standards, life expectancy and education, health and employment outcomes between them and non-Indigenous Australians. Action must be taken now to start closing the gap. The gap is most evident in remote areas, and it is the children living in some 1200 communities in northern and central Australia who are most seriously affected. Preventable diseases are common and many residents are illiterate and innumerate. An epidemic of alcohol and other substance abuse, violence and anti-social behaviour is destroying lives in many remote communities (Closing the Gap 2008, page 3).

**Outcomes**
We have set targets:
- to close the life-expectancy gap between Aboriginal and Torres Strait Islander people and other Australians within a generation;
- to halve the mortality gap between Aboriginal and Torres Strait Islander children and other children under age 5 within a decade;
- to halve the gap in literacy and numeracy achievement between Aboriginal and Torres Strait Islander students and other students within a decade;
to halve the gap in employment outcomes for Aboriginal and Torres Strait Islander people within a decade;
- to at least halve the gap in attainment at Year 12 schooling (or equivalent level) by 2020; and
- to provide all Aboriginal and Torres Strait Islander four year olds in remote communities with access to a quality preschool program within five years.

COAG has formally adopted these targets, and has identified a number of strategic platforms or 'building blocks' that need to be in place in order to comprehensively address the current state of disadvantage:
- healthy homes;
- safe communities;
- health;
- early childhood;
- schooling;
- economic participation; and
- governance and leadership.

(Closing the Gap 2008, page 7)

**Key points/aspects**

We have set targets:
- to close the life-expectancy gap between Aboriginal and Torres Strait Islander people and other Australians within a generation;
- to halve the mortality gap between Aboriginal and Torres Strait Islander children and other children under age 5 within a decade;
- to halve the gap in literacy and numeracy achievement between Aboriginal and Torres Strait Islander students and other students within a decade;
- to halve the gap in employment outcomes for Aboriginal and Torres Strait Islander people within a decade;
- to at least halve the gap in attainment at Year 12 schooling (or equivalent level) by 2020; and
- to provide all Aboriginal and Torres Strait Islander four year olds in remote communities with access to a quality preschool program within five years

(Closing the Gap 2008, page 7).

Achieving these ambitious targets will not be easy. It requires strong commitment and coordinated action within and across governments, robust mechanisms for advancing reforms, and an accountability framework that reports on progress. It is vital that the States and Territories are partners in this process.

In short, we want to achieve a situation where:
• there are agreed objectives — we all know where we are going and the outcomes we want to achieve;
• roles and responsibilities are clearly defined; and
• there is transparency and accountability (Closing the Gap 2008, page 8).

COAG has formally adopted these targets, and has identified a number of strategic platforms or ‘building blocks’ that need to be in place in order to comprehensively address the current state of disadvantage:
• healthy homes;
• safe communities;
• health;
• early childhood;
• schooling;
• economic participation; and
• governance and leadership (Closing the Gap 2008, page 8).

Implementation
This document forms part of the Federal Government’s 2008-09 budget.

Review processes
The Government will be accountable for outcomes for Indigenous Australians, hence our commitment to measurable targets and milestones and to regular reporting. On the first working day of each parliamentary year the Prime Minister will report to Parliament on progress on our specific targets. The necessary corollary is transparent monitoring to measure progress across government. Through the COAG Working Group on Indigenous Reform we will be progressing arrangements for independent national monitoring and reporting of progress against agreed targets (Closing the Gap 2008, page 37).

Outcomes to date
The Final Budget Outcome for the 2008-09 financial year will be released late 2009.27

Amount of money allocated
Appendix 1 of original document outlines new and redirected funding following the 2007 election and 2008-09 budget measures.

Appendix 2 outlines 2008-09 Indigenous Budget Measures.

No clearly stated relationship with:
Aboriginal and Torres Strait Islander Health Performance Framework
National Framework of Principles for Government Service Delivery to Indigenous Australians
National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Well Being: 2004 – 2009
Framework for Reporting on Indigenous Disadvantage
Cultural Respect Framework for Aboriginal and Torres Strait Islander Health
Good practice framework. Policing illicit drugs in rural and remote Aboriginal and Torres Strait Islander communities
A National Framework for improving the health and wellbeing of Aboriginal and Torres Strait Islander Males
Be active Australia: a framework for health sector action for physical activity 2005-2010.
Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005 – 2008
Closing the Gap between Indigenous and non-Indigenous Australians
National Drug Strategy Aboriginal and Torres Strait Islander Peoples’ Complementary Action Plan 2003-2009
A Fairer Victoria 2009
A Fairer Victoria 2008: Strong People, Strong Communities
Department of Human Services Aboriginal Services Plan 2008-2010
Aboriginal Cultural Competence Framework
Because Mental Health Matters: Victorian Mental Health Reform Strategy 2009-2019
A Plan for Action 2005 - 2007 Promoting Mental Health and Wellbeing
Strong Culture, Strong Peoples, Strong Families: towards a safer future for Indigenous families and communities 10 year plan
Aboriginal Child Placement Principle Guide


2d  Australia’s National Oral Health Plan 2004-2013

A copy of the National Aboriginal and Torres Strait Islander Oral Health Workshop – Workshop Report and Action Plan cannot be found. There is however, Australia’s National Oral Health Plan 2004-2013 which has a specific section relating to ATSI oral health.

**Governance**

While the Commonwealth continues to play a direct and indirect role in the provision and financing of dental services, responsibility for the delivery of the major public programs for children and disadvantaged adults is managed by the States and Territories (Australia’s National Oral Health Plan 2004, page v).

**ATSI involvement**

Not specified.

**Jurisdiction**

Who will be involved?

- Aboriginal and Torres Strait Islander people
- Aboriginal health workers
- General medical practitioners
- Oral health practitioners and their professional associations
- The tertiary education sector
- The primary and secondary education sectors
- Rural and remote media
- State/Territory and Commonwealth governments
- National Aboriginal Community Controlled Health Organisation
- Standing Committee on Aboriginal and Torres Strait Islander Health

**Longevity**

July 2004 - 2013

Within each of its Action Areas, the Plan presents national actions to achieve:

- improvements in the short term, over the next two years (2004-2006);
- change in the medium term, to be pursued over the next five years (2004 to 2009); and
- more fundamental change in the longer term, to be pursued over the next ten years (to 2013)
Level of impact
Healthy Mouths Healthy Lives represents an understanding on the part of the Commonwealth, State and Territory governments, the oral health care professions and consumer groups to work co-operatively to achieve its outcomes (Australia’s National Oral Health Plan 2004, page 1).

Relationship to other instruments

Linked initiatives (specific to ATSI action area)
National Strategic Framework for Aboriginal and Torres Strait Islander Health
National Aboriginal Health Strategy
National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan
The Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework
The NHMRC Road Map: A Strategic Framework for Improving Aboriginal and Torres Strait Islander Health through Research
National Public Health Partnership
Patient-assisted Transport Scheme (each state has one of these)
Primary Health Care Access Program
National Rural Health Alliance

Aim
The purpose of Healthy Mouths Healthy Lives: Australia’s National Oral Health Plan 2004–2013 (“the Plan”) is to improve health and wellbeing across the Australian population by improving oral health status and reducing the burden of oral disease. The Plan aims to help all Australians to retain as many of their teeth as possible throughout their lives, have good oral health as part of their general good health, and have access to affordable and quality oral health services (Australia’s National Oral Health Plan 2004, page v).

Australia’s best oral health services are equal to the best in the world. The Plan aims to spread this good practice, achieve equitable distribution of preventive and treatment
services, and address the significant shortage within the oral health workforce (Australia’s National Oral Health Plan 2004, page vi).

Rationale
Traditionally, Aboriginal and Torres Strait Islander peoples experienced good oral health, with minimal oral diseases. With the change in lifestyle and dependence on new introduced foods, oral diseases are now common in most Aboriginal and Torres Strait Islander communities, comprising one aspect of the many serious health problems experienced by Aboriginal and Torres Strait Islander peoples. Aboriginal and Torres Strait Islander peoples comprise 2.4 percent of the total Australian population, based on 1996 Census figures, with almost 26.5 percent living in areas classified as rural and remote, compared to 2 percent of the total population (ABS and AIHW 2003). Compared to the overall Australian population of similar age, among Aboriginal and Torres Strait Islander peoples:

- children generally have more than twice the caries experience and a greater proportion of untreated caries;
- adults have more missing teeth; and
- periodontal health is worse, with poor periodontal health evident in younger populations.

(Australia’s National Oral Health Plan 2004, page 34)

In 2002, a workshop was held on Aboriginal and Torres Strait Islander Oral Health, under the auspices of the National Aboriginal and Torres Strait Islander Health Council and the Standing Committee of Aboriginal and Torres Strait Islander Health. The National Aboriginal and Torres Strait Islander Oral Health Action Plan developed at that workshop (Commonwealth Department of Health and Ageing 2003) is a major step towards addressing the oral health needs of these populations, and forms the basis of this Healthy Mouths Healthy Lives Action Area (Australia’s National Oral Health Plan 2004, page 34)

Principles for action
The National Aboriginal and Torres Strait Islander Oral Health Action Plan (Commonwealth Department of Health and Ageing 2003) is based on nine principles outlined in the National Strategic Framework for Aboriginal and Torres Strait Islander Health (see Appendix 6) (Australia’s National Oral Health Plan 2004, page 35).

Outcomes
The Plan comprises a set of interrelated National Actions which collectively will ensure improvement in the oral health status and general health of the Australian community (Australia’s National Oral Health Plan 2004, page viii).
Outcomes for action area 6:
Good oral health for Aboriginal and Torres Strait Islander peoples, commensurate with that of the overall Australian population, which supports good health and quality of life; achieved in culturally supportive ways through:

- enhanced understanding of Indigenous health issues in the community;
- collaborative approaches to oral health planning and delivery;
- improved public health measures that address oral health;
- local and timely access, according to need, to affordable, culturally appropriate dental care; and
- improved collection, quality and dissemination of oral health information about Aboriginal and Torres Strait Islander people


Key points/aspects
Four broad themes underpin the Plan:

- recognition that oral health is an integral part of general health;
- a population health approach, with a strong focus on promoting health and the prevention and early identification of oral disease;
- access to appropriate and affordable services – health promotion, prevention, early intervention and treatment – for all Australians; and
- education to achieve a sufficient and appropriately skilled workforce, and communities that effectively support and promote oral health


Importantly, there is a strong focus on reducing the major disparities in oral health status and inequities in access to oral health care (Australia’s National Oral Health Plan 2004, page vi).

Aboriginal and Torres Strait Islander communities have defined a number of principles that are fundamental to work with these communities, but which also have wide application. These principles, set out on page 35, cover cultural respect, a holistic approach, health sector responsibility, community control of primary health services, working together in partnership to improve health determinants, localised decision-making, recognising health promotion as a core component of primary health care, building community and health service capacity, and accountability for health outcomes (Australia’s National Oral Health Plan 2004, page 14).

Within an overarching population health framework, the Plan identifies seven interrelated areas for action,
• Promoting Oral Health Across The Population
• Children & Adolescents
• Older People
• Low Income & Social Disadvantage
• People with Special Needs
• Aboriginal and Torres Strait Islander Peoples
• Workforce


Within each Action Area, the Plan presents national actions to achieve:
• improvements in the short term, over the next two years (2004-2006);
• change in the medium term, to be pursued over the next five years (2004 to 2009);
• more fundamental change in the longer term, to be pursued over the next ten years (to 2013)


Priority research areas
The following research areas have been identified under each of the Action Areas of the plan.
Aboriginal and Torres Strait Islander peoples
• The prevalence, incidence and health and social effects of oral diseases among Aboriginal and Torres Strait Islander peoples, and the risk and protective factors for oral health in these communities.
• Oral health promotion activities and programs that are effective in Aboriginal and Torres Strait Islander communities in bringing about changes in attitudes, beliefs and behaviours in relation to oral health.
• Best practice protocols for treating oral diseases in Aboriginal and Torres Strait Islander peoples, including the management of periodontal disease in diabetic people.
• The impact of access to timely and regular dental care in allowing older Indigenous Australians to maintain functional independence for longer.
• The mix of dental workforce that is best able to meet the needs of Indigenous Australians across the lifespan in a sustainable way

### Implementation

<table>
<thead>
<tr>
<th>Action Area Six: Aboriginal and Torres Strait Islander Peoples: Implement the National Aboriginal and Torres Strait Islander Oral Health Action Plan (Commonwealth Department of Health and Ageing 2003), including the following actions</th>
<th>Timeframe</th>
</tr>
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<tbody>
<tr>
<td>6.1 Support the proposal to include under Medicare a biennial adult health assessment for Aboriginal and Torres Strait Islander peoples, which includes an oral examination.</td>
<td>Short</td>
</tr>
</tbody>
</table>
| 6.2 Provide culturally appropriate and accessible oral health services through:  
  - partnerships between Indigenous-specific and mainstream health services at a regional level;  
  - provision of patient-assisted transport schemes;  
  - increasing the proportion of mainstream dental services that provide culturally appropriate services. | Short |

**See also:**

1.2 Extend fluoridation of public water supplies to communities across Australia with populations of 1000 or more.

7.4 Improve recruitment and retention of oral health professionals in public dental services through enhanced professional development, improved career paths and more competitive pay scales.

7.8 Develop and implement programs, including dedicated student places and scholarships, to increase recruitment of Aboriginal and Torres Strait Islander oral health students.

| 6.3 Increase oral health promotion activity for Aboriginal and Torres Strait Islander peoples by:  
  - developing strategies targeting Aboriginal and Torres Strait Islander oral health, both as stand alone and integral to other health promotion activities (e.g., diabetes, cardiovascular disease, tobacco and alcohol control, nutrition);  
  - improving access to oral hygiene materials (toothbrushes, paste, floss);  
  - improving access to nutritious and affordable food supply. | Medium |

| 6.4 Foster the integration of oral health within health systems and services, particularly with respect to primary health care, by:  
  - inclusion of oral health into health check guidelines for well people, and recall mechanisms for people with chronic illnesses. | Medium |
• integrating oral health into relevant Aboriginal and Torres Strait Islander health policy.

6.5 Improve the collection and quality of oral health information on Aboriginal and Torres Strait Islander people by:
• developing an agreed national Indigenous oral health data set;
• consolidating existing data on oral health;
• regular standardised collection and dissemination of oral health data.

6.6 Consistent with the National Aboriginal and Torres Strait Islander Workforce National Strategic Framework, increase the oral health workforce available to improve the oral health of Aboriginal and Torres Strait Islander people by:
• increasing the number of Aboriginal and Torres Strait Islander people working across the oral health professions, including provision of scholarships for Aboriginal and Torres Strait Islander students;
• clarifying roles and recognising Aboriginal and Torres Strait Islander health workers as a key component of the oral health workforce;
• addressing the role and development needs of the oral health Workforce contributing to Aboriginal and Torres Strait Islander health;
• improving training, recruitment and retention measures for oral health staff working in Aboriginal primary health services;
• expanding the role of dental therapists, dental hygienists and oral health therapists.


Review processes
Note: These indicators may need to be adapted to ensure consistency with the National Aboriginal and Torres Strait Islander Health Performance Framework currently under development.

Process indicators
• Percentage of oral health staff in the public sector who have undergone cultural awareness training
• Percentage of Aboriginal children having general anaesthetics for oral health problems
• Percentage of Aboriginal communities with access to fluoridated drinking water
• Percentage of Aboriginal Health Workers who have received oral health training
• Publication of regular reports from the Indigenous oral health data set
• Number of Aboriginal persons in oral health courses in Australian universities

**Outcome indicators**

• Reduction in backlog of dental needs and symptom experience among Aboriginal and Torres Strait Islander people
• Reduction in prevalence of oral diseases among Aboriginal and Torres Strait Islander people including dental caries and periodontal diseases
• Reduction of oral health inequalities in oral health between Aboriginal and Torres Strait Islander people and the rest of the Australian population
• Improved oral-health-related quality of life, as recorded by indicators such the oral health impact profile (OHIP)


**Monitoring and evaluation**

Key performance indicators have been set to monitor the implementation and outcomes of Healthy Mouths Healthy Lives. These include process and outcome indicators specified for each Action Area, and the following overall indicators:

• Percentage of dentate population reporting a social impact (eg toothache, difficulty chewing, concerned about appearance) because of problems with teeth, mouth or gums in last 12 months by age group, living circumstance, card status, Indigenous status and special needs
• Percentage of population with untreated decay by age group, living circumstance, card status, Indigenous status and special needs
• The proportion of the dentate population with a maximum periodontal pocketing of 3.5 mm and 5.5 mm, by age
• Mean number of missing teeth and proportion of existing teeth with untreated decay by age group, living circumstance, card status, Indigenous status and special needs
• Percentage of dentate population who visited dental practitioner in last 2 years by age group, living circumstance, card status, Indigenous status and special needs
• Percentage of dentate population whose reason for visiting dental practitioner in last 12 months was for a check-up, by age group, living circumstance, card status, Indigenous status and special needs
• Number of dental practitioners per 100,000 population by indices of remoteness.
• Number of curricula of undergraduate and continuing education programs for health workers that include a module on oral health
• Percentage of population by State/Territory having access to water fluoridation.
A representative group of government and non-government stakeholders should be resourced and given the task of measuring and reporting on these indicators (Australia’s National Oral Health Plan 2004, page 14).

**Outcomes to date**
No outcomes data was found using basic web search. Plan runs until 2013.

**Amount of money allocated**
Not specified
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<tr>
<td>Quantitative measurement of framework</td>
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<tr>
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<tr>
<td>Builds on approaches in this document</td>
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<tr>
<td>Relationship stated but unclear</td>
<td>Tan</td>
</tr>
</tbody>
</table>
Relationship stated but unclear: National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013

National Drug Strategy Aboriginal and Torres Strait Islander Peoples' Complementary Action Plan 2003-2009

Approaches are built upon in: Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005-2008

Builds on approaches in this document: National Aboriginal Health Strategy 1989
No clearly stated relationship with:

Aboriginal and Torres Strait Islander Health Performance Framework
National Framework of Principles for Government Service Delivery to Indigenous Australians
National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being: 2004 – 2009
Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework Framework for Reporting on Indigenous Disadvantage
Cultural Respect Framework for Aboriginal and Torres Strait Islander Health
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National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan 2000 – 2010
Closing the Gap between Indigenous and non-Indigenous Australians
Australia's National Oral Health Plan 2004-2013
Victorian Indigenous Affairs Framework - Improving the lives of Indigenous Victorians
A Fairer Victoria 2009
A Fairer Victoria 2008: Strong People, Strong Communities
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Strong Culture, Strong Peoples, Strong Families: towards a safer future for Indigenous families and communities 10 year plan
Aboriginal Child Placement Principle Guide
2e National Drug Strategy Aboriginal and Torres Strait Islander Peoples’ Complementary Action Plan 2003-2009

Governance
The Australian Government provides national leadership in Australia’s response to reducing the harmful use of alcohol, tobacco and other drugs. The National Drug Strategic Framework, prepared under the direction of the Ministerial Council on Drug Strategy (MCDS), represents a shared vision, a framework for cooperation and a basis for coordinated action to reduce the harm caused by drugs in Australia (National Drug Strategy ATSI People’s Complementary Action Plan 2006, page 6).

Key roles to be played by a number of Australian Government departments including the Department of Health and Ageing; Department of Family and Community Services; Department of Education, Science and Training; Attorney-General’s Department; the Australian Customs Service; and the Australian Federal Police. In addition, Aboriginal Hostels Limited play a key role in supporting and resourcing Aboriginal and Torres Strait Islander drug and alcohol programs (National Drug Strategy ATSI People’s Complementary Action Plan 2006, page 6).

ATSI involvement
The action plan recognises that government, non-government and Aboriginal and Torres Strait Islander community-controlled organisations must work together to address the social, economic, environmental and physical health inequalities experienced by Aboriginal and Torres Strait Islander peoples. It represents the views of both Aboriginal and Torres Strait Islander, and non-Aboriginal and Torres Strait Islander peoples, and highlights a range of realistic and achievable strategies (National Drug Strategy ATSI People’s Complementary Action Plan 2006, page 1).

During the development of other national action plans under the National Drug Strategic Framework 1998-99 to 2002-03 (National Drug Strategic Framework) it was recognised that Aboriginal and Torres Strait Islander peoples’ needs were not specifically addressed. The Aboriginal and Torres Strait Islander Peoples’ Reference Group was established to negotiate the development of this action plan (National Drug Strategy ATSI People’s Complementary Action Plan 2006, page 4).

Jurisdiction
The Aboriginal and Torres Strait Islander Peoples’ complementary action plan highlights the need for effective partnerships to help make the best use of available resources and provide a whole-of-system response to the use of alcohol, tobacco and other drugs. This will require working across levels of government, across portfolios, with Aboriginal
and Torres Strait Islander community-controlled organisations, and with the communities themselves (National Drug Strategy ATSI People’s Complementary Action Plan 2006, page 5).

**Longevity**
May 2006 to present.

**Level of impact**
The mission of the National Drug Strategic Framework is to improve health, social and economic outcomes by preventing the uptake of harmful drug use and reducing the harmful effects of licit and illicit drugs in Australian society. In line with the framework, this action plan is not intended to be prescriptive or to define detailed implementation methods. Rather, it sets a national direction for reducing harm associated with use of alcohol, tobacco and other drugs. It provides an opportunity for communities, non-government organisations, Aboriginal and Torres Strait Islander community-controlled organisations and all levels of government to pursue strategies that are specifically relevant to Aboriginal and Torres Strait Islander peoples and appropriate to their circumstances, needs and aspirations. It encourages careful attention to the specific needs of Aboriginal and Torres Strait peoples in implementing the other relevant national action plans (National Drug Strategy ATSI People’s Complementary Action Plan 2006, page 4).

**Relationship to other instruments**
The *National Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003–2006* and its accompanying documents were endorsed by the Ministerial Council on Drug Strategy (MCDS) on 1 August 2003. The action plan was prepared by the National Drug Strategy Reference Group for Aboriginal and Torres Strait Islander Peoples with the help and support of Siggins Miller Consultants. The Intergovernmental Committee on Drugs, the Australian National Council on Drugs, Aboriginal and Torres Strait Islander people in every State and Territory, the National Aboriginal Community Controlled Health Organisation, and a broad range of other key stakeholders contributed to its drafting (National Drug Strategy ATSI People’s Complementary Action Plan 2006, inside cover).

In March 2006, the MCDS approved the extension of the *National Aboriginal and Torres Strait Islander Peoples Complementary Action Plan* from 2003-2006 to 2003-2009 to bring it into line with the *National Drug Strategy - Australia’s Integrated Framework 2004-2009*. The (MCDS) is the peak policy and decision-making body in relation to licit and illicit drugs in Australia. It brings together Commonwealth, State and Territory
Ministers responsible for health and law enforcement to collectively determine national policies and programs to reduce drug-related harm. The MCDS ensures that the Australian approach to harmful drug use is nationally coordinated and integrated. Its collaborative approach is designed to achieve national consistency in policy principles, program development and service delivery (National Drug Strategy ATSI People’s Complementary Action Plan 2006, inside cover).

The action plan adopts the definition of health used in the National Aboriginal Health Strategy Report 1989, which in turn is based on the definition of the World Health Organisation.

**Definitions**

**Health**: not just the physical wellbeing of the individual but the social, emotional, and cultural wellbeing of the whole community. This is a whole-of-life view and life-death-life.

**Primary health care**: Essential health care based on practical scientifically sound, socially and culturally acceptable methods and technology made universally accessible to individuals and families in the communities in which they live through their full participation at every stage of development in the spirit of self-reliance and self-determination (National Drug Strategy ATSI People’s Complementary Action Plan 2006, page 1).

This action plan has been developed to complement the existing national tobacco, alcohol, and illicit drugs action plans under the National Drug Strategy Framework. It is a companion action plan to the whole-of-population action plans. The hope is that this complementary or companion plan will achieve the benefits of both Aboriginal and Torres Strait Islander-specific approaches and integrated effort by linking closely with existing mainstream whole-of-population action plans and informing implementation of the national strategy (National Drug Strategy ATSI People’s Complementary Action Plan 2006, page 39).

The framework agreements have the potential to play a key role in the implementation of this action plan. At the national level, the National Aboriginal and Torres Strait Islander Health Council (NATSIHC) is the forum established to provide policy advice to the Commonwealth Minister responsible for health. The Aboriginal and Torres Strait Islander community controlled health sector and Aboriginal and Torres Strait Islander substance use expertise are represented on this council. NATSIHC has developed the National Strategic Framework for Aboriginal and Torres Strait Islander Health that includes substance misuse as one of its nine priorities for government action (National Drug Strategy ATSI People’s Complementary Action Plan 2006, pp 6-7).

**Aim**

The mission of the National Drug Strategic Framework is to improve health, social and economic outcomes by preventing the uptake of harmful drug use and reducing the harmful effects of licit and illicit drugs in Australian society. In line with the framework, this action plan is not intended to be prescriptive or to define detailed implementation methods. Rather, it sets a national direction for reducing harm associated with use of alcohol, tobacco and other drugs (National Drug Strategy ATSI People’s Complementary Action Plan 2006, page 4).

**Rationale**

During the development of other national action plans under the National Drug Strategic Framework 1998-99 to 2002-03 (National Drug Strategic Framework) it was recognised that Aboriginal and Torres Strait Islander peoples’ needs were not specifically addressed. The Aboriginal and Torres Strait Islander Peoples’ Reference Group was established to negotiate the development of this action plan.

It provides an opportunity for communities, nongovernment organisations, Aboriginal and Torres Strait Islander community-controlled organisations and all levels of government to pursue strategies that are specifically relevant to Aboriginal and Torres Strait Islander peoples and appropriate to their circumstances, needs and aspirations. It encourages careful attention to the specific needs of Aboriginal and Torres Strait peoples in implementing the other relevant national action plans (National Drug Strategy ATSI People’s Complementary Action Plan 2006, page 4).

**Outcomes**

**Key result areas**

The action plan is structured around six key result areas.
1. Enhanced capacity of Aboriginal and Torres Strait Islander individuals, families and communities to address current and future issues in the use of alcohol, tobacco and other drugs and promote their own health and wellbeing.

2. Whole-of-government effort and commitment, in collaboration with community controlled services and other non-government organisations, to implement, evaluate and continuously improve comprehensive approaches to reduce drug-related harm among Aboriginal and Torres Strait Islander peoples.

3. Substantially improved access for Aboriginal and Torres Strait Islander peoples to the appropriate range of health and wellbeing services that play a role in addressing the use of alcohol, tobacco and other drugs.

4. A range of holistic approaches from prevention through to treatment and continuing care that is locally available and accessible.

5. Workforce initiatives to enhance the capacity of Aboriginal and Torres Strait Islander community-controlled and mainstream organisations to provide quality services.


Each key result area contains a number of objectives, key action areas and examples of actions. The objectives are structured around actions that apply to the whole result area; control of supply, demand management, harm reduction, early intervention and treatment (National Drug Strategy ATSI People’s Complementary Action Plan 2006, page 7).

**Key points/aspects**

**Principles**

The following principles must underlie any action to address the use of alcohol, tobacco and other drugs in Aboriginal and Torres Strait Islander populations.

- Use of alcohol, tobacco and other drugs must be addressed as part of a comprehensive, holistic approach to health that includes physical, spiritual, cultural, emotional and social wellbeing, community development and capacity building.
- Local planning is required to develop responses to needs and priorities set by local Aboriginal and Torres Strait Islander communities.
- Culturally valid strategies that are effective for Aboriginal and Torres Strait Islander peoples must be developed, implemented and evaluated.
- Aboriginal and Torres Strait Islander peoples must be centrally involved in planning, development and implementation of strategies to address the use of alcohol, tobacco and other drugs in their communities.
Aboriginal and Torres Strait Islander communities should have control over their health, drug and alcohol and related services.

Resources to address the use of alcohol, tobacco and other drugs must be available on the basis of need, and at the level required to reduce disproportionate levels of drug-related harm by Aboriginal and Torres Strait Islander peoples.

Examples of how these principles have been put into action have been included, where appropriate, in the action plan (National Drug Strategy ATSI People’s Complementary Action Plan 2006, page 4).

**Implementation**

A whole-of-government approach is critical for effective implementation of this action plan, with key roles to be played by a number of Australian Government departments including the Department of Health and Ageing; Department of Family and Community Services; Department of Education, Science and Training; Attorney-General’s Department; the Australian Customs Service; and the Australian Federal Police. In addition, Aboriginal Hostels Limited play a key role in supporting and resourcing Aboriginal and Torres Strait Islander drug and alcohol programs.

State, Territory and local governments also have key roles in implementing this action plan, and in drawing up their own plans for prioritising need. Recognising the important role of local government, the IGCD recently established a local government subcommittee to allow perspectives from local government to be considered within the framework in a manner consistent other IGCD committees (National Drug Strategy ATSI People’s Complementary Action Plan 2006, page 6).

**Review processes**

In addition to these national-level indicators, it is expected that at State and Territory and regional levels jurisdictions will collect their own performance information to monitor aspects of implementation of each of these action plans that are particularly relevant locally (National Drug Strategy ATSI People’s Complementary Action Plan 2006, page 39).

Specific national indicators for the National Aboriginal and Torres Strait Islander Complementary Action Plan 2003–2006

- An increase in the capacity to report nationally on improvements for Aboriginal and Torres Strait Islander populations in meeting the mainstream performance indicators specified by the substance-specific national action plans.
- The number of regional health plans developed under the partnership agreements that incorporate ATOD strategies listed in the complementary action plan.
- Evidence that all appropriate workforce, research, and evaluation and monitoring actions that arise from funding for the substance-specific action plans are developed in line with the intentions of the complementary action plan to improve capacity and to promote holistic models of intervention (National Drug Strategy ATSI People’s Complementary Action Plan 2006, page 40).

**Outcomes to date**
No outcomes data found using basic web search. Plan runs until 2009.

**Amount of money allocated**
Not specified.
Guided by the principles of | Pink
Share priority areas | Green
Implementation plan of framework | Light Blue
Quantitative measurement of framework | Red
Implementation through this plan/strategy | Grey
To be considered/included in the planning process | Purple
Evaluation/monitoring tool of framework | Orange
Builds on approaches in this document | Orange
Relationship stated but unclear | Tan
3 Policies and Frameworks – Victoria
3a Victorian Indigenous Affairs Framework – Improving the lives of Indigenous Victorians

- Considered in the planning process of: Department of Human Services Aboriginal Services Plan 2003-2013
- Included in the planning process of: Australia’s National Oral Health Plan 2004-2013
- Implementation plan of: Cultural Respect Framework for Aboriginal and Torres Strait Islander Health
- Implementation plan of: Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework
- Implemented: National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013
- Shares Priorities Areas with: Framework for Reporting on Indigenous Disadvantage
- Relationship stated but unclear: A Fairer Victoria 2009
- Relationship stated but unclear: National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013
- Relationship stated but unclear: A Fairer Victoria 2009: Strong People, Strong Communities
- Unclear relationship stated: National Framework for Improving the health and wellbeing of Aboriginal and Torres Strait Islander Males
- Unclear relationship stated: National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan 2008-2010
- Unclear relationship stated: Strong Culture, Strong Peoples, Strong Families: towards a safer future for Indigenous families and communities 10 year plan
No clearly stated relationship with:
Aboriginal and Torres Strait Islander Health Performance Framework
National Framework of Principles for Government Service Delivery to Indigenous Australians
National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being: 2004 – 2009
Good practice framework. Policing illicit drugs in rural and remote Aboriginal and Torres Strait Islander communities
Be active Australia: a framework for health sector action for physical activity 2005-2010.
Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005 – 2008
Closing the Gap between Indigenous and non-Indigenous Australians
National Drug Strategy Aboriginal and Torres Strait Islander Peoples' Complementary Action Plan 2003-2009
Aboriginal Cultural Competence Framework
Because Mental Health Matters: Victorian Mental Health Reform Strategy 2009-2019
A Plan for Action 2005 - 2007 Promoting Mental Health and Wellbeing
Aboriginal Child Placement Principle Guide
3 Policies and Frameworks - Victoria

3a Victorian Indigenous Affairs Framework - Improving the lives of Indigenous Victorians

Governance
Victorian Government.

ATSI involvement
Since the abolishment of ATSIC and ATSIS, Framework Agreements and Forums will in future involve the three remaining partners plus the Torres Strait Regional Authority. The development of Indigenous Coordination Centres at the regional level will provide one mechanism for ongoing representation of Aboriginal communities in whole-of-government planning and priority-setting. State policy managers from the Office for Indigenous Policy Coordination have been invited to participate in the Forums.28

Jurisdiction
In conjunction with the Premier, government leadership for Aboriginal affairs is centred on the Ministerial Taskforce for Aboriginal Affairs (MTAA). First established in 2006, the taskforce is responsible for overseeing government implementation of the Victorian Indigenous Affairs Framework (VIAF) (DHS Aboriginal Services Plan 2008, page 7).

Longevity

Level of impact
To ensure that there is co-ordination of effort, and to provide whole of government leadership, the Government established a Ministerial Taskforce on Aboriginal Affairs to direct the implementation of the VIAF (Victorian Indigenous Affairs Framework Report 2008, page 4).

From the Government perspective this leadership is centred with the Premier and the members of the Ministerial Taskforce for Indigenous Affairs. Whole of Government co-ordination will be 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 over the three years to 2008-09 (Victorian Indigenous Affairs Framework 2006, page 10).

Relationship to other instruments

A Fairer Victoria (2005, 06, 07, 08)
- A Fairer Victoria 2008 does not have strategies specific to Indigenous Victorians.

Overcoming Indigenous Disadvantage Framework
- The priority outcomes mirror the nationally endorsed Overcoming indigenous Disadvantage Framework.

The National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013
- Commits Commonwealth, state and territory governments to work together on joint initiatives between health and other portfolios to ensure Aboriginal people enjoy a healthy life equal to the general population.

Aboriginal Services Plan 2004
- The Victorian implementation plan is based on the Aboriginal Services Plan 2004.

Aim
This Framework will:
- enable better alignment and integration of policy and program effort across sectors;
- identify accountabilities for Government departments and agencies to deliver measurable improvements against agreed indicators of Indigenous well-being;

The VIAF comprises the following four elements which are designed to achieve the Government’s overarching goal to raise life expectancy and quality of life for Indigenous Victorians:
- Principles for reform;
- Strategic policy framework;
- Performance framework; and
**Rationale**

The Agreements on Aboriginal and Torres Strait Islander Health (Framework Agreements) are the primary vehicle for ensuring collaboration in resource allocation, joint planning and priority setting for service delivery between key stakeholders in Indigenous health within each state and territory.\(^{29}\)

Aboriginal Health Forums or partnerships are established under the Framework Agreements to oversee this collaborative work.\(^{30}\)

Until 30 June 2004 the signatories to the Framework Agreements and membership of the Forums included: the Australian Government; State/Territory governments; the Aboriginal community controlled health sector; and ATSIC and the Torres Strait Regional Authority.\(^{31}\)

The Framework Agreements commit signatories to four key areas:\(^{32}\)

- Increased level of resources allocated to reflect the level of need;
- Joint planning;
- Access to both mainstream and Aboriginal and Torres Strait Islander specific health and health related services which reflect their higher level of need; and
- Improved data collection and evaluation.

**Outcomes**

Focusing efforts of the Victorian *strategic areas for action* (see diagram on page 6 of document) for the short to medium term will lay the groundwork for achieving sustainable, long term improvements in the following *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; and
- Improved wealth creation and economic sustainability for Individuals, families and communities

(Victorian Indigenous Affairs Framework 2006, page 7)

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Key points/aspects

<table>
<thead>
<tr>
<th>The Victorian strategic areas for action are to:</th>
<th>Nationally agreed Strategic Areas for Action outlined in COAG OID framework to which Victorian Government is a signatory</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Improve maternal health and early childhood health and development</td>
<td>1. Early childhood development and growth (prenatal to 3 years)</td>
</tr>
<tr>
<td>2. Improve literacy and numeracy</td>
<td>2. Early school engagement and performance (preschool to year 3)</td>
</tr>
<tr>
<td>3. Improve year 12 completion or equivalent qualification and develop pathways to employment</td>
<td>3. Positive childhood and transition to adulthood</td>
</tr>
<tr>
<td>4. Prevent family violence and improve justice outcomes</td>
<td>4. Substance abuse and misuse</td>
</tr>
<tr>
<td>5. Improve economic development settle native title claims and address land access issues</td>
<td>5. Functional and resilient families and communities</td>
</tr>
<tr>
<td>7. Economic participation and development</td>
<td></td>
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</tbody>
</table>

(Victorian Indigenous Affairs Framework 2006, page 7)

A set of 21 strategic change indicators is designed to measure progress in each of the six strategic areas for action. New representative arrangements will increasingly help to engage with the Aboriginal community (Victorian Aboriginal Services Plan 2008, page 43).

Implementation

The Ministerial Taskforce on Aboriginal Affairs has been created to focus government efforts on closing the 17 year life expectancy gap that exists between Indigenous and non-Indigenous Victorians. The Taskforce focuses on reducing Indigenous inequalities – especially those relating to early childhood, education, employment and participation in the civic, social and cultural life of the Victorian community. The challenge requires generational change, and the Victorian Government is working in partnership with Indigenous communities and the Commonwealth Government to achieve this.  

The role of the Taskforce is to:
- Oversee Victorian Government activities to address Aboriginal disadvantage through the Victorian Indigenous Affairs Framework (PDF 1998 kb) and the emerging Council of Australian Government's (COAG)
- Identify priorities for policy and program action
- Ensure representative and engagement arrangements for Aboriginal Victorians create strong, sustained and effective partnerships with Government, and
- Monitor the effectiveness of government strategies.

The Taskforce is chaired by the Deputy Premier, Rob Hulls MP and includes:
- Minister for Aboriginal Affairs, Richard Wynne MP
- Minister for Children and Early Childhood Development, Maxine Morand MP
- Minister for Community Services, Lisa Neville MP
- Minister for Education, Brownyn Pike MP
- Minister for Finance, Tim Holding MP
- Minister for Health, Daniel Andrews MP
- Minister for Skills and Workforce Participation, Hon Jacinta Allan MP

The Taskforce is supported by the Secretaries’ Group on Aboriginal Affairs and by a Secretariat located in the Department of Planning and Community Development. 34

Review processes
The VIAF Performance Framework commits the Government to achieve improvements against the Strategic Change Indicators for the Victorian Strategic Areas for Action of the VIA (see page 8 of document for Strategic Change Indicators).

The Strategic Change Indicators have been selected as valid markers on route to longer term change in reducing Indigenous disadvantage. Achieving improvements in The Strategic Change Indicators match the Victorian strategic areas for action against which improvements can be made over a 5, 10 and 15 year period in keeping with the COAG generational plan timetable. (Victorian Indigenous Affairs Framework 2006, page 8)

The 2003-04 reports will be the last in the current format. From 2004-05, Framework Agreement reporting will be incorporated into the reports against Implementation Plans for the National Strategic Framework for Aboriginal and Torres Strait Islander Health. 35

Outcomes to date

- As at January 2008, three annual progress reports had been developed on the outcomes of Victoria’s implementation plan and presented to the Australian Health Ministers’ Advisory Council.\(^{36}\)

- Development of Ministerial Taskforce on Aboriginal Affairs (MTAA)

  MTAA drives action and provides whole-of-government direction. It has a continuing focus on outcomes for children and young people. The Taskforce was established in 2006 and comprised:
  - Minister for Aboriginal Affairs (chair)
  - Attorney General
  - Minister for Children
  - Minister for Education
  - Minister for Skills, Education Services and Employment.


- Developed new community engagement and representative arrangements

  Result is graduated three tier structure for Indigenous governance comprising 38 Local Indigenous Networks, eight Regional Indigenous Councils, and the Premier’s Aboriginal Advisory Council. The Premier’s Aboriginal Advisory Council will include Regional Indigenous Council and Indigenous peak body representation. The Local Indigenous Networks and Regional Indigenous Councils will provide a new opportunity for existing leaders, help identify new leaders, and provide a way for Indigenous Victorians to participate, contribute, and be recognised for their contribution to the broader community. They will also strengthen the capacity of Indigenous people to participate in mainstream planning processes.


Amount of money allocated

Some funding allocations mentioned in the Indigenous Affairs Report 06-07 include:

- The 2007 Victorian State Budget included a commitment of $2.9 million to conduct a comprehensive study into the health and well-being of young Indigenous Victorians


- As part of the implementation of the new child and family legislation an additional $1.4 million was committed in November 2006 to assist Indigenous community controlled organisations build their capacity to deliver a range of child and family welfare services (Victorian Indigenous Affairs Framework Report 2006-2007, page 25).
<table>
<thead>
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Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework
Framework for Reporting on Indigenous Disadvantage
Cultural Respect Framework for Aboriginal and Torres Strait Islander Health
Good practice framework. Policing illicit drugs in rural and remote Aboriginal and Torres Strait Islander communities
A National Framework for improving the health and wellbeing of Aboriginal and Torres Strait Islander Males
Be active Australia: a framework for health sector action for physical activity 2005-2010.
National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan 2000 – 2010
Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005 – 2008
Australia's National Oral Health Plan 2004-2013
National Drug Strategy Aboriginal and Torres Strait Islander Peoples' Complementary Action Plan 2003-2009
A Fairer Victoria 2008: Strong People, Strong Communities
Department of Human Services Aboriginal Services Plan 2008-2010
Aboriginal Cultural Competence Framework
A Plan for Action 2005 - 2007 Promoting Mental Health and Wellbeing
Aboriginal Child Placement Principle Guide
3b A Fairer Victoria 2009

Governance
Victorian Government.

Document name
A Fairer Victoria 2009
This is a broad document with some information specific to ATSI people, however, many of the initiatives will also impact on ATSI people, whether or not this is directly specified in the text.

ATSI involvement
Not specified.

Jurisdiction
The journey towards A Fairer Victoria is very much a shared one. It is about partnerships with the community services sector, with business and philanthropic organisations (A Fairer Victoria 2009, page 4).

Longevity
First launched in 2005, then annually.

Level of impact
A Fairer Victoria is a whole-of-government social policy action plan that remains unique in Australia as a long-term commitment to reducing disadvantage. 37

Relationship to other instruments
Victorian Indigenous Affairs Framework

Aim
The four key priorities of A Fairer Victoria are to:
- help all Victorian children get the best start in life
- improve education opportunities and help people into work
- improve health and wellbeing and reduce health inequalities

• develop liveable communities where Victorians will want to live, work and raise families.

(A Fairer Victoria 2009, page 6)

Rationale
A Fairer Victoria 2009 responds to new challenges in a time of global uncertainty. It continues to protect the most vulnerable and invest in the education, skills, health and wellbeing of our people and communities to build Victoria’s collective capacity and resilience (A Fairer Victoria 2009, page 6).

Outcomes
(Only outcomes that specifically mention Indigenous or ATSI have been included)

In the 2009-10 Budget we will invest $150 million over four years to continue our significant reforms in child protection services. In Out of Home Care this includes:

• better meeting the needs of Aboriginal children in care by improving cultural competency (A Fairer Victoria 2009, page 20).

Supporting Indigenous children
The aim of the National Partnership on Indigenous Early Childhood Development is to give all Indigenous children a good start. Victoria is committed to a range of ambitious national targets, including halving the gap in mortality rates for Indigenous children under five within a decade. Funding from the national partnership will go towards:

• establishing two Children and Family Centres to bring together maternity services, child care, kindergarten, and other family services at a single site
• delivering stronger ante natal and sexual reproductive health support
• providing greater support for the specialist health workforce to meet the needs of Indigenous children and families
• increased provision of maternal and child health services for Indigenous children and their mothers.

We will also expand the Koori Maternity Service Program to better support vulnerable Aboriginal children and their families in Darebin, Greater Bendigo and Mildura. (A Fairer Victoria 2009, page 21)

Key points/aspects
(Only information relating to Indigenous people has been included in this summary)

Improving the lives of Indigenous Victorians
In partnership with Indigenous communities, the Victorian Government has taken significant steps to improve the lives of Indigenous Victorians. The Victorian Indigenous
Affairs Framework now includes action plans to address 21 key areas. The government will also set 5, 10 and 15 year targets under these key areas as an important step towards closing the gap. The framework provides a platform for concerted action and a basis for measuring improvements over time. As part of this process, the government recently signed a communiqué prepared by Victoria’s Indigenous community as an indication of its commitment to the partnership that directs the framework (A Fairer Victoria 2009, page 11).

In 2008, COAG agreed to six ambitious targets for Closing the Gap between Indigenous and non-Indigenous people. Covering life expectancy, early childhood education, school education, child mortality and economic participation, these targets served to focus the attention of all Australians, including governments, on the significant work required to close gaps in outcomes for Indigenous people (A Fairer Victoria 2009, page 11).

In addition to other initiatives, A Fairer Victoria 2009 reflects new investments in Indigenous wellbeing made possible through National Partnership Agreements in early years, education and health. All are focused squarely on improving outcomes for Indigenous Victorians (A Fairer Victoria 2009, page 11).

We will work with the Victorian Aboriginal Community Controlled Health Organisation and the Victorian Aboriginal Health Service to better coordinate support for Indigenous Victorians with a mental illness. An Indigenous mental health hub will provide culturally sensitive services and a critical bridge to the specialist mental health and broader social support systems (A Fairer Victoria 2009, page 44).

Closing the Gap for Indigenous Victorians Indigenous people continue to experience a life expectancy many years lower than that of other Victorians. Closing this gap over the coming generation is a key commitment of the Victorian Government and Council of Australian Governments (A Fairer Victoria 2009, page 45).

In partnership with the Commonwealth, we will introduce a range of health reforms across a number of key areas to improve Indigenous health. The priorities are preventing illness by tackling health-compromising conditions and behaviours, improving access to quality health care, stepping up efforts to reduce smoking and obesity and strengthening management of chronic disease in hospital and primary health care settings (A Fairer Victoria 2009, page 45).

This will only be effective when the status of Indigenous Victorians as our First Peoples and our rich Indigenous cultural heritage is recognized community-wide. The Department of Human Services will develop a Reconciliation Action Plan to help build
positive relationships and respect between Indigenous and non-Indigenous Victorians. The Reconciliation Action Plan will focus on employment for Indigenous people, cultural education and development in the Department and stronger relationships with Indigenous partners (A Fairer Victoria 2009, page 45).

The Government will extend funding to Stolen Generations Victoria to meet the continuing needs of Indigenous Victorians affected by past practices of removing Indigenous children from their families, communities and culture. Funding will be used to improve services, supports and advocacy for members of the Stolen Generations, to help the Public Record Office improve access to records, and to allow the Koorie Heritage Trust to continue its family heritage history service, linking Indigenous Victorians to their families (A Fairer Victoria 2009, page 45).

Consistent with the tobacco strategy, the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) is administering a project on behalf of the Department of Human Services to reduce smoking among Aboriginal women during pregnancy. The project provides training and organisational support to build the capacity of the Aboriginal health workforce to deliver smoking reduction and cessation interventions (A Fairer Victoria 2009, page 47).

As part of the National Partnership Agreement on Indigenous Housing with the Commonwealth, the Victorian Government has also agreed to take over supervision from the Commonwealth of around 500 Indigenous housing properties. Under this partnership, $30 million will be invested over 10 years to improve and maintain these properties and support Indigenous Community Housing Organisations to make the shift to the state’s regulatory framework (A Fairer Victoria 2009, page 56).

Funding will be provided to strengthen governance and strategic management of the Lake Tyers Aboriginal Trust, and other activities which nurture Aboriginal leadership and build management expertise in Victoria (A Fairer Victoria 2009, page 62).

**Implementation**
A Fairer Victoria’s success requires new partnerships among communities, the non-government sector, business and other levels of government to improve the planning and delivery of services at a local level.38

**Review processes**

Previous A Fairer Victoria Documents can be accessed on the [Department of Planning and Community Development website](http://www.planning.vic.gov.au). These include reports on achievements so far.

**Outcomes to date**

Outcomes as a result of previous A Fairer Victoria plans include:

- Increased the number of Indigenous children accessing maternal and child health services from 1,655 children in 2002-03 to 2,383 children in 2007-08 (A Fairer Victoria 2009, page 19).

- established the Aboriginal Health Promotion and Chronic Care Partnership program, to support Aboriginal Victorians to live healthier lives and improve management of chronic disease through culturally appropriate services (A Fairer Victoria 2009, page 42).

**Amount of money allocated**

The below allocations relate to Indigenous specific budget items.

- National Partnership on Closing the Gap in Indigenous Health Outcomes $47.4 million (A Fairer Victoria 2009, page 52).


- Indigenous Leadership and Capacity Building ‡ $0.7 million (A Fairer Victoria 2009, page 67).
  ‡ Over 1 year

National Partnerships with the Commonwealth

- National Partnerships on Closing the Gap in Indigenous Health Outcomes (Victoria’s portion of $805.5 million Commonwealth funding not yet finalised.) (A Fairer Victoria 2009, page 52)

- National Partnership on Indigenous Housing*** 17.9 over 4 years (A Fairer Victoria 2009, page 67)
  *** $30.4 million over 10 years.
### A Fairer Victoria Budget Overview $ million over 4 years*

<table>
<thead>
<tr>
<th>Priority Area</th>
<th>$ million</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority Area 1 – Getting the Best Start</td>
<td>215.0</td>
</tr>
<tr>
<td>Priority Area 2 – Reducing Educational Inequality and Helping People into Work</td>
<td>96.6</td>
</tr>
<tr>
<td>Priority Area 3 – Improving Health and Wellbeing</td>
<td>288.6</td>
</tr>
<tr>
<td>Priority Area 4 – Developing Liveable Communities</td>
<td>325.4</td>
</tr>
</tbody>
</table>

**TOTAL 2009-10 BUDGET INITIATIVES** 925.6

* Period is 2009-10 to 2012-13. Includes some individual initiatives with funding in 2008-09.

### National Partnerships with the Commonwealth

| TOTAL                   | 788.8** |

** This includes State contributions for the following National Partnerships:
- Closing the Gap in Indigenous Health
- Preventive Health
- Homelessness.

No clearly stated relationship with:
National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003 – 2013
Aboriginal and Torres Strait Islander Health Performance Framework
National Framework of Principles for Government Service Delivery to Indigenous Australians
National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Well Being: 2004 – 2009
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Aboriginal Cultural Competence Framework
A Plan for Action 2005 - 2007 Promoting Mental Health and Wellbeing
Aboriginal Child Placement Principle Guide
3c A Fairer Victoria 2008: Strong People, Strong Communities

**Governance**
Victorian Government.

**ATSI involvement**
Not specified.

**Jurisdiction**
Key whole of government initiatives will continue to help tackle complex problems that cut across the traditional responsibilities of individual Ministers and departments (A Fairer Victoria 2008, page 11).

**Longevity**
First launched in 2005, then annually.


A Fairer Victoria is a whole of Government social policy action plan to address disadvantage and promote inclusion and participation. This year A Fairer Victoria has a new look and sharper focus, targeting four priority areas. This re-focusing means a more concentrated effort in the key areas that will continue to make a difference to disadvantaged and vulnerable Victorians.39

**Level of impact**
Obligatory.

**Relationship to other instruments**
Victorian Indigenous Affairs Framework
Since 1999, the Government has made the biggest investment in programs to address Indigenous disadvantage in Victoria’s history. This is framed by a sustained, long-term plan – the Victorian Indigenous Affairs Framework – aimed at achieving measurable improvements against key outcomes over the next generation. A Fairer Victoria 2008

builds on these investments and reinforces new priorities to improve education and employment opportunities for Aboriginal children through a significant schools’ reform package (A Fairer Victoria 2008, page 33).

These initiatives will contribute to the Government’s overarching goal through the Victorian Indigenous Affairs Framework to close the gap in life expectancy and improve quality of life for Indigenous Victorians. Breaking the cycle of disadvantage for children, reducing education inequalities and getting more people into jobs are important objectives in the partnership between the Brumby Government and Victoria’s Indigenous leaders (A Fairer Victoria 2008, page 33).

**Aim**
Indigenous partnerships to address disadvantage through our sustained, long-term plan the Victorian Indigenous Affairs Framework. This aims to achieve measurable improvements against 1 key outcomes for Indigenous people over the next generation, including closing the 17-year gap in life expectancy. The strategic areas for action have a strong focus on young children and their education and are driven by a Ministerial Taskforce on Aboriginal Affairs chaired by the Deputy Premier (A Fairer Victoria 2008, page 11).

**Rationale**
Our goal is for communities in which everybody shares in the benefits of growth. Our new priorities build on past efforts and the best available evidence about the areas where government and community effort is most likely to result in sustainable gains for vulnerable Victorians by addressing the underlying causes and not just the symptoms (A Fairer Victoria 2008, page 4).

**Outcomes**
A Fairer Victoria 2008

**Getting the best start**
- Early years support for children and families most at risk

**Improving education and helping people into work**
- Reducing educational inequality, supporting young people at risk and reducing barriers to workforce participation

**Improving health and wellbeing**
- Reducing health inequalities and promoting wellbeing

**Developing liveable communities**
Key points/aspects
A Fairer Victoria 2005-7 had specific mention of indigenous Victorians. A Fairer Victoria 2008 does not have specific focus on indigenous Victorians.

Four critical priorities for economic and social participation are:
• giving all Victorian children the best start in life
• improving education and helping people into work
• improving health and wellbeing, and
• developing liveable communities (A Fairer Victoria 2008, page 9).

The package will also support a 10-year plan addressing Indigenous family violence, developed by the Indigenous community in partnership with the Government (priority area 1) (A Fairer Victoria 2008, page 23).

The Government has an ambitious reform agenda to address disadvantage in education and training and has released discussion papers on a Blueprint for Early Childhood Development and School Reform. The aim is to improve education and early childhood outcomes so that all children learn and develop, with stronger attention on the needs of Indigenous children and young people with a disability, and increased support for vulnerable families (priority area 2) (A Fairer Victoria 2008, page 29).

Greater support will be given to early school leavers in particular parts of the state where there are risks of noncompletion and unemployment, and to Indigenous young people and children being cared for out of the family home. There will also be a revitalized effort to improve workforce participation among adult jobseekers with low skills and other disadvantages. Victorians who have most difficulty getting and staying in paid work will be assisted by linking community support services with new employment and training opportunities (priority area 2) (A Fairer Victoria 2008, page 30).

We will extend the Literacy Improvement Teams of 5 experts for a further three years and appoint an additional 15 literacy experts for schools with high enrolments of Indigenous children. These teams build the capacity of classroom teachers and school leaders to achieve sustained improvement in literacy outcomes for all students (priority area 2) (A Fairer Victoria 2008, page 31).

Each Indigenous student will have their own educational plan to lift their educational achievements and job prospects. The Koorie Education Support Workforce will better support students and forge better links between schools, families and their communities. The key focus is on improving literacy and numeracy, with specialist support staff to run accelerated literacy and numeracy programs for under-performing
students. Fifteen specialists will be targeted to schools with high numbers of Indigenous students (A Fairer Victoria 2008, page 33).

We will also increase economic opportunities with a tailored Learning and Working program to reduce the number of young Indigenous people in Victoria who become long-term unemployed. This practical program will help Indigenous young people gain the skills and find the jobs, and work with families and communities to get over the local barriers to jobs and training. These education and work reforms support other important initiatives that will build on the strength of Victoria’s Aboriginal communities (A Fairer Victoria 2008, page 33).

The welfare and safety of Aboriginal children with complex needs and who are unable to live at home will be improved by expanding the level of support for their kinship carers. This will improve the sustainability of care placements and increase the child’s life chances. More resources will also be provided to Aboriginal Community Controlled Organisations to develop the skills and management of their workforce, and improve in-house systems to meet requirements under Victoria’s child protection legislation, thereby improving the delivery of services to vulnerable children and families (A Fairer Victoria 2008, page 33).

Following on from the success of Koorie courts at a Magistrate’s level, the Koorie County Court will be established to provide access to a higher court that is more culturally accessible, acceptable and comprehensible to the Koorie community. This will increase community confidence in the criminal justice system and reinforce the status of Elders and Respected Persons (A Fairer Victoria 2008, page 33).

Tackling the causes of preventable disease by encouraging physical activity, better nutrition and oral health, continually improving mental health services and the wellbeing and life options of people with a disability are among the important challenges. Strategies addressed in other sections such as preventing family violence (the single most important contributor to ill health for women aged 15-5 in Victoria) and improving outcomes for Indigenous Victorians are also critical elements in our plan to reduce health inequalities (A Fairer Victoria 2008, page 39).

Social marketing campaigns will strengthen the prevention effort for HIV and other sexually transmissible diseases for the most vulnerable groups: young people, Indigenous people, gay men, the prison population, and culturally and linguistically diverse populations and those living in rural Victoria (A Fairer Victoria 2008, page 40).

Go for your life! is the Government’s overarching healthy and active living campaign, and this will be built upon with well-targeted programs in communities with a low health
status. Indigenous communities will be a major focus to help close the 17-year gap in life expectancy. The successful Aboriginal Health Promotion and Chronic Care Partnerships, funded through *A Fairer Victoria* 005, will be expanded to improve access to adult and child health checks, allied and oral health services, among other health prevention strategies. More work will be done to bridge mainstream and Aboriginal health services to better meet the needs of Indigenous Victorians. In addition, under *Go for your life!*, more support will be provided through physical activity grants to reduce ill-health linked to lifestyle (*A Fairer Victoria* 2008, page 40).

**Implementation**
*A Fairer Victoria* is based on new ways of doing things, not just about additional investment. Over the past three years we have forged new partnerships with communities and other levels of government based on the principles of prevention and early intervention and a focus on people and places with high needs (*A Fairer Victoria* 2008, page 11).

**The Importance of a Whole of Government Approach**
Key whole of government initiatives will continue to help tackle complex problems that cut across the traditional responsibilities of individual Ministers and departments.

**Indigenous partnerships** to address disadvantage through our sustained, long-term plan – the *Victorian Indigenous Affairs Framework*. This aims to achieve measurable improvements against 1 key outcomes for Indigenous people over the next generation, including closing the 17-year gap in life expectancy. The strategic areas for action have a strong focus on young children and their education and are driven by a Ministerial Taskforce on Aboriginal Affairs chaired by the Deputy Premier (*A Fairer Victoria* 2008, page 11).

**Review processes**
On 24 April the Premier launched *A Fairer Victoria: Achievements So Far*, which reports on the first two and a half years of implementation of *A Fairer Victoria*. Many of the initiatives are now underway and are starting to have an impact on peoples lives.40

**Outcomes to date**

**Amount of money allocated**

### A Fairer Victoria Budget Overview $ million over 4 years*

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*Period is 2008-09 to 2011-12. Includes some individual initiatives with funding in 2007-08.*

(A Fairer Victoria 2008, page 57)
Department of Human Services Aboriginal Services Plan 2008-2010

To be considered in the planning process:
- Victorian Indigenous Affairs Framework
- Improving the lives of Indigenous Victorians

To be considered in the planning process:
- National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013

Share priority areas:
- Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005-2008

To be considered in the planning process:
- Framework for Reporting on Indigenous Disadvantage (includes Overcoming Indigenous Disadvantage reports)
No clearly stated relationship with:
Aboriginal and Torres Strait Islander Health Performance Framework
National Framework of Principles for Government Service Delivery to Indigenous Australians
National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being: 2004 – 2009
Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework
Cultural Respect Framework for Aboriginal and Torres Strait Islander Health
Good practice framework. Policing illicit drugs in rural and remote Aboriginal and Torres Strait Islander communities
A National Framework for improving the health and wellbeing of Aboriginal and Torres Strait Islander Males
Be active Australia: a framework for health sector action for physical activity 2005-2010.
National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan 2000 – 2010
Closing the Gap between Indigenous and non-Indigenous Australians
Australia's National Oral Health Plan 2004-2013
National Drug Strategy Aboriginal and Torres Strait Islander Peoples' Complementary Action Plan 2003-2009
A Fairer Victoria 2009
A Fairer Victoria 2008: Strong People, Strong Communities
Aboriginal Cultural Competence Framework
Because Mental Health Matters: Victorian Mental Health Reform Strategy 2009-2019
A Plan for Action 2005 - 2007 Promoting Mental Health and Wellbeing
Strong Culture, Strong Peoples, Strong Families: towards a safer future for Indigenous families and communities 10 year plan
Aboriginal Child Placement Principle Guide
3d  Department of Human Services Aboriginal Services Plan 2008-2010

Governance
Victorian State Government

ATSI involvement
The development of the plan would not have been possible without contributions from Aboriginal signatory organisations, a range of staff in Aboriginal Community Controlled Organisations, through regional Aboriginal advisory groups and through individual consultations. The perspectives offered by Aboriginal communities have been much appreciated (DHS Aboriginal Services Plan 2008, page 1).

Consultation on the plan was undertaken with key stakeholders and involved:
- a presentation at the Aboriginal Human Services Forum on 20 July 2007
- meetings with the signatories to the 2004 plan
- visits to regions to consult with Department of Human Services’ Aboriginal advisory groups
- discussions with departmental head office and regional staff
- discussions with Commonwealth and state government agencies and mainstream representatives
- forwarding copies of the draft document to a range of stakeholders, including those unable to attend the consultation sessions.

Feedback from consultation led to significant revision and improvement in all components of the plan. Most importantly, the plan now positions Aboriginal culture and identity at its core and focuses on what the department can do in partnership with Aboriginal communities and key stakeholders to improve life expectancy and quality of life in this context (DHS Aboriginal Services Plan 2008, page 3).

Jurisdiction
In conjunction with the Premier, government leadership for Aboriginal affairs is centred on the Ministerial Taskforce for Aboriginal Affairs (MTAA). First established in 2006, the taskforce is responsible for overseeing government implementation of the Victorian Indigenous Affairs Framework (DHS Aboriginal Services Plan 2008, page 7).

The Secretaries’ Group was developed to inform and advise the MTAA. First established in 2005, the group provides leadership direction and develops strategies to improve Aboriginal policy coordination and service delivery. With these structures in place, all departments have a responsibility to work together and in partnership with Aboriginal communities to implement the Victorian Indigenous Affairs Framework and
address multi-dimensional disadvantage (Victorian DHS Aboriginal Services Plan 2008, page 7).

The Department of Human Services is responsible for the funding and delivery of a range of health, housing, aged care and community services in Victoria. The department recognises that improvements in these areas can generate better outcomes in other areas such as education, justice and employment (DHS Aboriginal Services Plan 2008, page 7).

**Longevity**
2008 – 2010

**Level of impact**

**Relationship to other instruments**
The Aboriginal Services Plan 2008-2010 has been developed in the context of a number of national and state strategies and policies designed to address Aboriginal disadvantage, including:

- Victorian Indigenous Affairs Framework;
- Overcoming Indigenous Disadvantage (OID) Framework
- National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013.

Strategies and recommendations from these frameworks, along with the Aboriginal Services Plan 2004, were used as the basis for the development of the first draft of this plan (DHS Aboriginal Services Plan 2008, page 3).

**DHS Departmental Plan 2007-08**
Where the objectives of the Departmental Plan 2007–08 are relevant to Aboriginal people, they have been included in the Aboriginal Services Plan 2008-2010. However, an additional objective, 'Improving outcomes in the early years and for Aboriginal youth' has also been incorporated. Many of the target outcomes identified in this plan also reflect the Departmental Plan 2007-08, with additional outcomes required to address the strong disadvantage faced by Aboriginal people. In terms of the challenges addressed by the Aboriginal Services Plan 2008-2010, these also correlate directly with the Departmental Plan 2007–08 (DHS Aboriginal Services Plan 2008, page 21).
**Children, Youth and Families Act 2005 (CYFA)** includes a number of reforms that will enhance service quality and effectiveness for Aboriginal families. These reforms include:

- the establishment of a Child FIRST intake system and a stronger, better resourced family services system with well developed cultural competency.
- the implementation of Section 18 of the CYFA 2005, which provides for the transfer of orders to Aboriginal agencies and the enhancement of the Aboriginal child placement principle (DHS Aboriginal Services Plan 2008, page 24).

**Child Wellbeing and Safety Act 2005** includes:

- the development of the Victorian Aboriginal Child Wellbeing Charter (0-18 years)

Key priority areas identified in state and national strategies relating to HIV/AIDS, Hepatitis C and STIs underpin these projects, particularly the:

- *Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005-2008*
- *Victorian Sexually Transmissible Infections Strategy 2006-2009*

(DHS Aboriginal Services Plan 2008, page 27) This list links to Objective 1.

Page 6 (DHS Aboriginal Services Plan 2008) has a map of relevant state and national frameworks and policies.

**Aim**


**Rationale**

The *Aboriginal Services Plan 2004* outlined the department’s commitment to improve the health and wellbeing of Aboriginal Victorians by better focusing resources and working in close partnership with Aboriginal people, organisations and communities. (DHS Aboriginal Services Plan 2008, page 3).

The 2008-2010 updated plan is more targeted, with specific priority areas highlighted to improve outcomes and help bridge the life expectancy gap between Aboriginal and non-

The plan supports policy and program development across the range of Department of Human Services’ responsibilities in health, mental health, drug and alcohol, aged care, disability, housing and children’s, youth and family services. Making a measurable difference for Aboriginal people remains our central focus (DHS Aboriginal Services Plan 2008, page 3).

**Outcomes**
(see page 19 for diagram).

The overarching goal of the department’s *Aboriginal Services Plan 2008–2010* is represented on the outside of the circle, highlighting a desire to end a situation in which Aboriginal people die on average 17 years younger than other Victorians, and experience a greater concentration of hardship and trauma over the course of their lives (DHS Aboriginal Services Plan 2008, page 18).

The next layer of the circle highlights some of the areas of social or economic disadvantage that affect Aboriginal people in relation to employment, housing, poverty, education and health. Also highlighted is the activity that needs to occur across government, mainstream and Aboriginal Community Controlled Organisations to create a positive difference (DHS Aboriginal Services Plan 2008, page 18).

The list of indicators is by no means exhaustive and in some instances, are just as relevant in all sectors of the circle rather than the sector they appear. Where possible, the department has attempted to reflect the wide range of topics discussed throughout the consultation process (DHS Aboriginal Services Plan 2008, page 18).

While the four sectors of the circle are interrelated and no one area of disadvantage can be addressed in isolation, the colour coding represents the shared responsibility for Aboriginal disadvantage. While acknowledging the value of existing efforts, governments, Aboriginal Community Controlled Organisations and mainstream agencies need to work together to create ‘real’ change in the health status of Aboriginal individuals, families and communities (DHS Aboriginal Services Plan 2008, page 18).

A more supportive and coordinated response will help build protective factors and contribute to achieving long term physical, spiritual, cultural, emotional and social wellbeing (represented by the white circle). At the core of the circle is Aboriginal culture and identity, the very essence of what it means to be a strong and proud Aboriginal person. As the department’s efforts to address Aboriginal disadvantage continue, the
importance of culture and identity provide a central focus, while the goal of increasing life expectancy and quality of life remains our highest priority (DHS Aboriginal Services Plan 2008, page 18).

**Key points/aspects**

Objective 1: Reducing inequalities through improving health and wellbeing, particularly for disadvantaged people and communities (pp25-27)
Objective 2: Improving outcomes in the early years and for Aboriginal Youth (pp28-29)
Objective 3: Promoting least intrusive and earliest effective care (pp30-31)
Objective 4: Strengthening the capacity of individuals, families and communities (pp32-33)

**Implementation**

Aboriginal Human Services Forum
The Aboriginal Human Services Forum was established in 2002. Its role is to provide the department’s senior executive, Aboriginal signatory organisations and regional Aboriginal representatives with an opportunity to have an active dialogue about issues affecting Aboriginal people in Victoria. Through effective two-way communication and information sharing, the Aboriginal Human Services Forum will assist in the governance, implementation and monitoring of this plan (DHS Aboriginal Services Plan 2008, page 4).

Regional Aboriginal services plans
Underpinning the 2004 statewide plan, each Department of Human Services region developed a regional plan addressing local priorities. The eight departmental regions will review and update these regional Aboriginal services plans where necessary in the context of the 2008-2010 statewide plan (DHS Aboriginal Services Plan 2008, page 4).

Aboriginal Planning Officers and regional Aboriginal advisory groups
The department’s Aboriginal Planning Officers and the regional Aboriginal advisory groups in each of the department’s eight regions have further facilitated respectful engagement, consultation and planning at the local level (DHS Aboriginal Services Plan 2008, page 4).

**Review processes**

Each year, data from divisions and regions will be brought together in a consolidated Aboriginal Services Plan Key Indicators report to highlight the progress made against

Progress and achievements against this plan will be reported regularly to the members of the Aboriginal Human Services Forum. At the local level, regional Aboriginal advisory groups will be active partners in the development and monitoring of regional plans (DHS Aboriginal Services Plan 2008, page 40).

The Koori Human Services Unit will also develop annual progress reports, including updated data, newly identified challenges and opportunities, as well as information on developments and improvements in the service system to better respond to the needs of Aboriginal people (DHS Aboriginal Services Plan 2008, page 40).


The department will monitor the implementation of the Aboriginal Services Plan 2008-2010. The performance indicators will be used to measure the achievement of outcomes. The Koori Human Services Unit will liaise with divisions and regions regarding the achievement of outcomes and, where necessary, provide assistance to identify and overcome barriers, which may affect those achievements. The Aboriginal Human Services Forum will continue to be the department’s principal means of ensuring the plan is a live and dynamic document. At the local level, regional Aboriginal advisory groups are active partners in the development and monitoring of regional plans (DHS Aboriginal Services Plan 2008, page 40).

**Outcomes to date**
The Aboriginal Services Plan Key Indicators reports on the implementation and progress of the Aboriginal Services Plan 2008-2010.

**Amount of money allocated**
Not specified.
Aboriginal Cultural Competence Framework
No clearly stated relationship with:
National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003 – 2013
Aboriginal and Torres Strait Islander Health Performance Framework
National Framework of Principles for Government Service Delivery to Indigenous Australians
National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being: 2004 – 2009
Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework Framework for Reporting on Indigenous Disadvantage
Cultural Respect Framework for Aboriginal and Torres Strait Islander Health
Good practice framework. Policing illicit drugs in rural and remote Aboriginal and Torres Strait Islander communities
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Closing the Gap between Indigenous and non-Indigenous Australians
Australia’s National Oral Health Plan 2004-2013
National Drug Strategy Aboriginal and Torres Strait Islander Peoples' Complementary Action Plan 2003-2009
Victorian Indigenous Affairs Framework - Improving the lives of Indigenous Victorians
A Fairer Victoria 2009
A Fairer Victoria 2008: Strong People, Strong Communities
Department of Human Services Aboriginal Services Plan 2008-2010
Because Mental Health Matters: Victorian Mental Health Reform Strategy 2009-2019
A Plan for Action 2005 - 2007 Promoting Mental Health and Wellbeing
Strong Culture, Strong Peoples, Strong Families: towards a safer future for Indigenous families and communities 10 year plan
Aboriginal Child Placement Principle Guide
3e Aboriginal Cultural Competence Framework

**Governance**
Victorian State government.

**ATSI involvement**
Victorian Aboriginal Child Care Agency (VACCA) was commissioned to develop an Aboriginal Cultural Competence Framework (Aboriginal Cultural Competence Framework 2008, page 3).

**Jurisdiction**
This framework will guide mainstream Community Service Organisations in the development of management strategies, policies and direct practice which will provide better outcomes for Aboriginal children and families (Aboriginal Cultural Competence Framework 2008, page 3).

**Longevity**
November 2008 - ongoing

**Level of impact**
Guiding.

**Relationship to other instruments**

*Children, Youth and Families Act 2005*

Provides a broad reform framework to deliver child and family services (Department of Human Services 2008, page 3). The *Children, Youth and Families Act 2005* provides for the Minister to determine performance standards for Community Service Organisations (CSOs) including cultural standards (s.59). This paper informs the registrations standards for CSOs providing community based child and family services and Out of Home Care Services as they relate to Aboriginal children and families and their communities (Department of Human Services 2008, page 7).

The *Children, Youth and Families Act 2005 (CYFA)* and the *Child Wellbeing and Safety Act 2005* set the broad framework for reforms in the child and family services sector. A foundational component of CYFA is the Best Interests of the Child principles which promote:

- the need, in relation to an Aboriginal child, to protect and promote his or her Aboriginal cultural and spiritual identity and development by, wherever possible,
maintaining and building their connections to their Aboriginal family and community (s.10).

The Children, Youth and Families Act includes other measures that specifically concern Aboriginal children and families. The Act:

- recognises the principle of self-determination and self-management for Aboriginal communities as part of the decision making process regarding Aboriginal children (s. 12)
- requires compliance with the Aboriginal Child Placement Principle, in recognition of children’s right to be raised in their own culture and the critical role of extended family, kinship networks, culture and community in raising Aboriginal children (s. 14)
- states that the Principal Officer of an Aboriginal agency can be authorised to perform functions and exercise powers regarding Protection Orders (s. 18)
- mandates preparation of cultural plans for Aboriginal children subject to guardianship or long term guardianship orders (s. 176)


Registration standards

One of the significant reforms of the CYFA is the promotion of high quality services through the registration of CSOs and the development of performance standards for child and family services and Out of Home Care services.

The standards place a high level of importance on developing culturally competent practice, in recognition that Aboriginal children, youth and families are overrepresented in child protection and Out of Home Care services and underrepresented in universal, preventive and family services (Aboriginal Cultural Competence Framework 2008, page 9).

The Aboriginal Cultural Competence Framework is part of a suite of documents related to the Children, Youth and Families Act 2005, the Child Wellbeing and Safety Act 2005 and the every child every chance reforms. The framework sits alongside the following key documents:

- The Best interests framework for vulnerable children and youth;
- Registration standards for community service organisations;
- Best interests principles: a conceptual overview
- The Best interests case practice model summary guide
- Cumulative harm: a conceptual overview
- Stability: a conceptual overview
- Child development and trauma guide and
- Promoting high quality community services for children, youth and families

(Aboriginal Cultural Competence Framework 2008, page 7)
Modern child development theory now points to the role culture plays in the child’s sense of identity and sense of belonging. The Looking After Children (LAC) Framework also acknowledges the importance of a child’s identity (Aboriginal Cultural Competence Framework 2008, page 16).

The Victorian Charter of Human Rights and Responsibilities Act 2006 recognises that Aboriginal people hold distinct Cultural rights, including:

“(a) the right to enjoy their identity and culture; and
(b) the right to maintain and use their language; and
(c) the right to maintain their kinship ties; and
(d) the right to maintain their distinctive spiritual, material and economic relationship with the land and waters and other resources with which they have a connection under traditional laws and customs.” (Charter of Human Rights and Responsibilities Act 2006, s.19)

Under the Act, it is unlawful for a public authority (such as a community service) to act in a way that is incompatible with a human right or, in making a decision, to fail to give proper consideration to a relevant human right. (Charter of Human Rights and Responsibilities Act 2006, s.38) (Aboriginal Cultural Competence Framework 2008, page 21).

Article 2 of the UN Charter and Article 1 of the International Covenant on Civil and Political Rights and the International Covenant on Social, Economic and Cultural Rights enshrine the rights of all distinct ethnic and cultural peoples to self-determination and define the right of self-determination as involving the free choice of political status and the freedom to pursue economic, social and cultural development. All people have the right to self-determination. Article 30 of the UN Convention on the Rights of the Child recognises the right of Indigenous children to enjoy their traditional culture. Children’s cultural identity is a key facet of their development and need to connect with their families and communities. Any definition of the rights of children, and any criteria that seek to determine what is in the best interests of the child, must recognise the right to culture as formative for identity and therefore that maintenance of cultural identity and connection is in the best interests of the child (Aboriginal Cultural Competence Framework 2008, page 21).

**Aim**

The Aboriginal Cultural Competence Framework that has been developed has six interrelated concepts that will assist CSOs and individual staff to be truly culturally competent. The benefits of cultural competence are that there will be greater engagement with Aboriginal communities, an appreciation of the richness and diversity

We hope that the *Aboriginal Cultural Competence Framework* will assist your organisation in forming partnerships with Aboriginal communities and services and providing cross-culturally competent practice and care. If we are to successfully look after children and provide support for families, using the lens of Culture and becoming culturally competent are key factors in enabling CSOs to provide the best services they can for Aboriginal children and families. Success in this regard will also be a significant step in the complex but necessary process of reconciliation (Aboriginal Cultural Competence Framework 2008, page 55).

**Rationale**

On Wednesday 13\textsuperscript{th} February 2008, the Prime Minister made a national apology to the Stolen Generations. It is in this context that the Victorian Government is committed to closing the gap between Aboriginal and non-Aboriginal people with respect to life expectancy, access to early childhood education, educational attainment and employment outcomes. In summary, this means working actively toward equal opportunity and improved outcomes for all Victorians (Aboriginal Cultural Competence Framework 2008, page 3).

This framework is designed to help Community Service Organisations define the vision and realities of cultural competence in the services they deliver. It will provide a solid foundation for improved outcomes for Aboriginal children and families as well better partnerships between these organisations and Aboriginal Community Controlled Organisations (Aboriginal Cultural Competence Framework 2008, page 3).

There are three key government policy drivers for the development of the Aboriginal Cultural Competence Framework

- Legislation – Children, Youth and Families Act 2005
- Registration standards. One of the significant reforms of the CYFA is the promotion of high quality services through the registration of CSOs and the development of performance standards for child and family services and Out of Home Care services (Aboriginal Cultural Competence Framework 2008, page 9).
- Best Interests Framework. Aboriginal cultural competence is a key facet of the Victorian Best Interests framework which interprets issues of children’s safety, stability and development through the lens of age and stage, culture and gender (Aboriginal Cultural Competence Framework 2008, page 10).
Outcomes
The Aboriginal Cultural Competence Framework that has been developed has six interrelated concepts that will assist CSOs and individual staff to be truly culturally competent. The benefits of cultural competence are that there will be greater engagement with Aboriginal communities, an appreciation of the richness and diversity of Aboriginal cultures and people, and better immediate and future outcomes for Aboriginal children and families (Aboriginal Cultural Competence Framework 2008, page 25).

Key points/aspects
The six interrelated concepts are:
- Cultural awareness (knowledge with understanding)
- Commitment to Aboriginal self-determination and respectful partnerships (the foundation for cultural competence)
- Cultural respect (attitude and values)
- Cultural responsiveness (ability and skills)
- Cultural safety (environment and client experience)

Implementation
Aboriginal Cultural Competence Matrix is designed to be used by Community Service Organisations in conjunction with the Registration Standards and the Evidence Guide 2008. The matrix provides detailed examples of evidence for the key components of the conceptual framework for Aboriginal cultural competence in accordance with the 8 Agency Standards (Aboriginal Cultural Competence Matrix 2008, page 1).

The matrix is a useful tool for meeting the cultural component in each of the agency registration standards. While the Aboriginal Cultural competence Framework articulates a best practice approach, agencies should find both the matrix and the practical examples suggested useful as they seek to deepen their level of Aboriginal cultural competence (Aboriginal Cultural Competence Matrix 2008, page 1).

Review processes
Not specified.

Outcomes to date
No outcomes data found using basic web search.

Amount of money allocated Not specified.
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Guided by the principles of: A Fairer Victoria 2008: Strong People, Strong Communities

Because Mental Health Matters: Victorian Mental Health Reform Strategy 2009-2019

Guided by the principles of: A Fairer Victoria 2009
No clearly stated relationship with:
National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003 – 2013
Aboriginal and Torres Strait Islander Health Performance Framework
National Framework of Principles for Government Service Delivery to Indigenous Australians
National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being: 2004 – 2009
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A Plan for Action 2005 - 2007 Promoting Mental Health and Wellbeing
Strong Culture, Strong Peoples, Strong Families: towards a safer future for Indigenous families and communities 10 year plan
Aboriginal Child Placement Principle Guide
This is a broad document with some information specific to ATSI people, however, many of the initiatives will also impact on ATSI people, whether or not this is directly specified in the text.

**Governance**
Victorian State Government.

**ATSI involvement**
Not specified.

**Jurisdiction**
A mental health system for the next decade puts partnerships at the centre of effective prevention, treatment and care. This includes partnerships between all levels of government, between the public, private and non-government sectors, and, importantly, between mental health services and consumers and carers (Because Mental Health Matters, page 9).

**Longevity**
Ten year plan.

**Level of impact**
These proposals do not imply the commitment at this point of specific additional financial or human resources. In many cases, action will be dependent on normal government budget processes and negotiation with the Commonwealth Government and other partners (Because Mental Health Matters, page 13).

**Relationship to other instruments**
A more complete list of current relevant policies and strategies is provided at Appendix 2 of original document.

This reflects the principles underpinning A Fairer Victoria, Victoria’s action plan to reduce disadvantage and strengthen social inclusion (Because Mental Health Matters, page 2).

The strategy builds on the sea change in approaches to mental health marked by the Council of Australian Governments (COAG) National Action Plan on Mental Health in 2006, and is informed by a range of significant recent reviews at state and national levels (Because Mental Health Matters, page 10).
The COAG National Action Plan on Mental Health of 2006 marked an important development in national mental health policy. Complementing the Third National Mental Health Plan, it emphasised coordination between government, private and non-government providers to deliver a more connected and comprehensive system of care. The roles of primary health care and social support services were given new prominence (Because Mental Health Matters, page 43).

As we move towards a fourth National Mental Health Plan, there is continued momentum for this kind of ‘joined-up’ approach. Victoria is keen to ensure that changes in the division of Commonwealth and state responsibilities in mental health maximise opportunities for the reforms described in this strategy. This means ensuring that the division of roles supports seamless service delivery to consumers, facilitates local innovation, and better meets the overall needs of populations (Because Mental Health Matters, page 43).

*A Fairer Victoria* has provided an important vehicle for harnessing commitment to action that improves the lives of disadvantaged Victorians. Recent moves to connect this to concerns about health inequalities, participation and productivity, and the way in which services are delivered, provide useful frameworks for mental health (Because Mental Health Matters, page 44).

The other important health policy framework for mental health is *Care in your community*. Focusing on community-based care, this strategy promotes collaborative area-based planning in order to support a progressive shift to cross-agency delivery of health services in community-based settings (Because Mental Health Matters, page 44).

In the mental health arena more specifically, it is important to note the concurrent review of the Victorian *Mental Health Act 1986*. This review, subject to separate consultative processes, will ensure that Victoria has an effective, contemporary legislative framework for mental health services (Because Mental Health Matters, page 44).

The *Victorian Charter of Human Rights and Responsibilities* represents a fundamental anchor for this review and, more broadly, for the strategy (Because Mental Health Matters, page 44).

Specific policies and strategies – existing or emerging – that are of particular significance to mental health include:

- **Vulnerable youth framework**
- **Restoring the Balance: Victoria’s Alcohol Action Plan 2008–2013**
- **A new blueprint for alcohol and other drug treatment services 2009–2013**
• Justice Statement II
• Blueprint for Education and Early Childhood Development
• Ageing in Victoria policy framework

(Because Mental Health Matters, page 44).

Aim
Over the next decade, effort across the eight Reform Areas detailed in this document will aim to deliver:

1. Larger scale, sustained prevention and mental health promotion activities in selected community settings.
2. Expanded effort to provide early support to children and young people, in partnership with universal services including schools.
3. Clearer and swifter pathways to care that are responsive to a greater range of clients and not dependent on people being in crisis.
4. A wider range of treatment options, with bed-based services as one element which can be matched to individual needs including options for those involved in the justice system.
5. More organised, tailored approaches to coordinating care for those needing longer term support to live successfully in the community, with greater focus on housing and workforce participation.
6. Improved social and emotional wellbeing for Aboriginal people and their families and better outcomes for a number of other specific population groups through the provision of culturally responsive care.
7. A refocused, flexible and sustainable workforce and a systematic drive to adopt effective, evidence-based practice.
8. Strengthened governance and local service coordination and planning partnerships bringing together clinical, psychosocial support and primary health providers.

(Because Mental Health Matters, page 10).

Rationale
This strategy has a major focus on meeting the needs of those who currently fall through the gaps in service provision, particularly those who are not severely ill enough to be prioritised for specialist services but who are either at an early stage of their illness or who have concurrent health and social issues that put them at risk (Because Mental Health Matters, page 31).

This strategy is the culmination of a process that began with the creation by the Victorian Government of a new ministry for mental health in November 2006 and has involved a partnership between many agencies across government. It builds on the
foundations laid by previous state reform policies and programs, including the deinstitutionalisation and mainstreaming achieved by the mid 1990s, the system of area mental health services put in place under the 1994 Framework for Service Delivery, and the 2002 plan New Directions for Victoria’s Mental Health Services which sought to strengthen the capacity of specialist services to respond to consumer needs across the illness pathway.

In late 2007, the Minister for Mental Health, the Hon. Lisa Neville MP, commissioned a range of preliminary consultations with external stakeholders to test initial directions. This led to further refinement of government thinking and the publication in May 2008 of the consultation paper Because mental health matters (Because Mental Health Matters, page 41).

4.5 Aboriginal Communities
Many Aboriginal Australians have significant mental health issues that are linked to experiences of grief, loss and trauma. Aboriginal people conceptualise mental health as part of social, spiritual and emotional wellbeing. Mental health and general health services therefore need to be sensitive to the cultural meanings and needs of Aboriginal people.

- Over a quarter of Aboriginal people are reported to have some form of mental illness.
- Higher rates of self harm and suicide in Aboriginal communities are indicative of poorer mental health outcomes in Aboriginal Australians compared to the general population.
- Higher rates of problematic alcohol and drug use are additional challenges to the maintenance of social, spiritual and emotional wellbeing.
- Aboriginal Australians also experience higher unemployment, financial stress and lower levels of educational attainment. They are more likely to live in poor quality housing than non-Aboriginal Australians. All of this has profound impacts on social, spiritual and emotional wellbeing.

The Victorian Government is committed to the national goal of closing the gap in life expectancy between Indigenous and non-Indigenous Australians within a generation. Strategies to improve the social, spiritual and emotional wellbeing of Aboriginal people, their families and community are addressed in Reform Area 6 (Because Mental Health Matters, page 49).

Outcomes
The proposed mental health outcomes framework provides a shared basis for planning – across the various levels of the service system, across government programs, and across agencies and sectors at the local level – and for monitoring how things are
improving. It will help assess the impact of current investments and inform decisions about new investments (Because Mental Health Matters, page 24).

Coupled with new structures that bring together key players in mental health at a local level, the outcomes framework will facilitate benchmarking across areas and targeting of resources to address identified gaps in local service provision (Because Mental Health Matters, page 24).

In line with national health performance frameworks, the proposed mental health outcomes framework will provide the basis for a set of agreed mental health indicators and measures across three levels, each of which covers a number of defined domains:

Level One: Health and community outcomes
Level Two: Determinants of mental health
Level Three: Performance of the service system

(Because Mental Health Matters, page 24).

At the local level, the various outcome measures will provide a mechanism to:

- identify and share best practice across the relevant service systems
- support performance benchmarking at the individual service level
- enable the identification of specific service weaknesses
- support the development of strategic cross-agency responses to address local needs.

(Because Mental Health Matters, page 25).

The outcomes framework will also provide a mechanism to identify and profile differences in access and health inequalities experienced in geographical areas and in specific population groups (for example, Aboriginal communities). Inclusion of social determinants of mental health in the outcomes framework acknowledges the importance of factors beyond the purview of the mental health service system in achieving desired mental health outcomes (Because Mental Health Matters, page 25).

A preliminary set of proposed outcomes at all three levels of the framework is outlined on pages 25-27 of document.

These will be further developed in the early stages of strategy implementation and regularly reviewed to ensure continued relevance to mental health reform (Because Mental Health Matters, page 25).

Indicators and progress measures will be developed for each of the nominated outcomes, drawing predominantly on existing data, and including age, gender, ethnicity and geographical location wherever possible. It is not intended that the outcomes
framework impose a new data burden on services or programs (Because Mental Health Matters, page 25).

(Only the Indigenous specific key points have been included here)

Reform Area 6: Reducing inequalities – responding better to vulnerable people

- Provide Aboriginal people living in metropolitan Melbourne with culturally supportive social and emotional wellbeing and recovery services delivered through new collaborative arrangements between the Victorian Aboriginal Health Services (VAHS), Victorian Aboriginal Community Controlled Health Organisations (VACCHO), local Aboriginal organisations and mental health services.

- Explore, with VACCHO and selected Aboriginal Community Controlled Health Organisations, a coordinated local prevention, early identification and intervention program targeted to young Aboriginal people aged 10–25 years at risk of, or experiencing, poor social and emotional wellbeing.

(Key points/aspects)

This vision for mental health and wellbeing in Victoria is built on the core elements of Prevention, Early intervention – early in life, illness and episode, Recovery and Social inclusion. (for more details see box 2 on page 22)

Progress in achieving this vision will be based on the principles of: consumer-centred service provision, population-based planning, a social model of health, equity and responsiveness to diversity, family and carer inclusion, and evidence-based practice. (for more details see box 3 on page 23)

At the core of our strategy must be well targeted interventions that seek to have real impact on a person’s illness and life trajectory (Because Mental Health Matters, page 22).

Realising the vision also depends on stronger partnerships across sectors, designed to foster shared responsibility to prevent mental health problems from emerging or escalating, and to assist those affected by mental health problems in a range of settings such as schools, sporting clubs, prisons, homelessness services, child protection and aged care (Because Mental Health Matters, page 22).

Central to achieving the vision will be a balanced and networked mental health system within which individuals can move easily between levels of care and between types of providers as their needs change (Because Mental Health Matters, page 22).
Implementation

Because mental health matters sets out a wide range of proposals. Some are well developed and can be implemented confidently in the short term; others require further consideration, development and testing. Implementation is commencing with seeding initiatives totalling $128 million over four years funded in the 2008–09 State Budget. All measures proposed require careful monitoring and evaluation. For these reasons, ongoing processes for driving reform are a critical part of this strategy. A new Victorian Mental Health Reform Council is proposed to assist in achieving the new vision (Because Mental Health Matters, page 10).

This strategy sets directions for change and development in policies, programs and services of the Victorian Government and its partners. It proposes a program of reform to be achieved in a staged way over a ten-year period. This will involve development of more concrete action plans, commencing in the first half of 2009. To support this change process, a range of new structures for driving and monitoring implementation are proposed, including a statewide Mental Health Reform Council and new local planning and governance structures. These are detailed under Reform Area 8 (Because Mental Health Matters, page 42).

Review processes

A preliminary set of proposed outcomes at all three levels of the framework is outlined on page 25 of the original document. These will be further developed in the early stages of strategy implementation and regularly reviewed to ensure continued relevance to mental health reform (Because Mental Health Matters, page 25).

Outcomes to date

Plan began in 2009.

Amount of money allocated

The resourcing of directions outlined in this document commenced in the 2008–09 State Budget, with $128 million over four years being made available for a number of initial seeding developments. Particular emphasis was placed in the first instance on:

- piloting child and youth mental health service development;
- perinatal mental health screening and support as part of a national initiative;
- better pathways to mental health care including a telephone advice and referral line and enhanced psychiatric triage;
- expansion of acute care capacity for people with severe eating disorders; and
- extension of recovery support linked to secure housing, including new models of Supportive Housing
  (Because Mental Health Matters, page 43).
No clearly stated relationship with:
National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003 – 2013
Aboriginal and Torres Strait Islander Health Performance Framework
National Framework of Principles for Government Service Delivery to Indigenous Australians
National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being: 2004 – 2009
Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework
Framework for Reporting on Indigenous Disadvantage
Cultural Respect Framework for Aboriginal and Torres Strait Islander Health
Good practice framework. Policing illicit drugs in rural and remote Aboriginal and Torres Strait Islander communities
A National Framework for improving the health and wellbeing of Aboriginal and Torres Strait Islander Males
Be active Australia: a framework for health sector action for physical activity 2005-2010.
National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan 2000 – 2010
Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005 – 2008
Closing the Gap between Indigenous and non-Indigenous Australians
Australia's National Oral Health Plan 2004-2013
National Drug Strategy Aboriginal and Torres Strait Islander Peoples' Complementary Action Plan 2003-2009
Victorian Indigenous Affairs Framework - Improving the lives of Indigenous Victorians
A Fairer Victoria 2009
A Fairer Victoria 2008: Strong People, Strong Communities
Department of Human Services Aboriginal Services Plan 2008-2010
Aboriginal Cultural Competence Framework
Because Mental Health Matters: Victorian Mental Health Reform Strategy 2009-2019
Strong Culture, Strong Peoples, Strong Families: towards a safer future for Indigenous families and communities 10 year plan
Aboriginal Child Placement Principle Guide

Governance
Victorian State government.

ATSI involvement
Yes, had an indigenous advisory group.

Jurisdiction
Victorian Health Promotion Fund (Victorian Government).

Longevity
2005.

Level of impact
VicHealth’s second mental health promotion plan has been designed not only to guide VicHealth’s work in mental health promotion, but also as a resource for those across a range of sectors who are seeking to maximise opportunities to promote mental health and wellbeing in their programs, policies and practices.41

Relationship to other instruments
Builds on the following:
Mental Health Promotion Plan Foundation Document: 1999-2002
The Mental Health Promotion Plan Foundation document represents the work of over 100 organisations which joined in partnership with VicHealth to develop a framework for promoting mental health within Victoria and for identifying areas for action. Evidence confirms that mental health is linked to social and community connectedness, participating in supportive relationships, freedom from discrimination and a valued social position.42

Mental Health Promotion Plan 1999-2002
The Mental Health Promotion Foundation document formed the basis of the VicHealth Mental Health Promotion Plan. It represents the work of intersectoral organisations from across Victoria and is an action plan for promoting mental health across Victoria. The Plan gives direction for investment in a range of populations because of their inherent vulnerability to psychosocial pressures, isolation, poverty and discrimination. These

include rural people, older and younger people, Kooris and new arrivals to Australia.43

**Aim**
The Framework is based on the understanding that long-term improvements in mental health are likely to be achieved by supporting sustained changes in individual skills and knowledge and in the broader environment. Accordingly, the health promotion actions are designed for implementation at a societal level (e.g. in legislation and regulatory frameworks), at an organisational level (e.g. in schools and workplaces), at a community level (e.g. by building social cohesion) and at an individual level (e.g. by building skills and resilience) (A Plan for Action: Promoting Mental Health and Well Being 2005, page 20).

By facilitating social inclusion, reducing discrimination and violence and improving access to economic resources through these actions and at these levels, VicHealth aims to reduce stress, anxiety and depression and to promote positive mental health (A Plan for Action: Promoting Mental Health and Well Being 2005, page 20).

**Rationale**
VicHealth has identified mental health as a continuing priority in its Strategic Plan 2003–2007. This update on the original Mental Health Promotion Plan has been developed to guide VicHealth activity in this area and serve as an information resource for policy-makers, researchers, community organisations and practitioners working across sectors. It draws on the lessons learned in the course of implementing and evaluating the Mental Health Promotion Plan 1999–2002, on the emerging evidence and on policy directions at both the national and international levels. It refines VicHealth’s Mental Health Promotion Framework and outlines key directions for research and implementation activity to be undertaken during 2005–2007 (A Plan for Action: Promoting Mental Health and Well Being 2005, page 6).

**Indigenous communities: Rationale**
While there are no reliable national data on Indigenous mental health, the indications are that this group have poorer mental health than non-Indigenous Australians. For example:

- in 2001–02, Aboriginal and Torres Straight Islander people were hospitalised for mental health and behavioural disorders at a higher rate than the general population and their rates of admission for mental disorders due to substance abuse were four to five times higher than for the non-Indigenous population (AIHW 2004); and

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• death rates for suicide among Indigenous men are over twice those for non-Indigenous men and for Indigenous women are nearly twice the non-Indigenous rate (AIHW 2004).

There are a range of historical and contemporary factors influencing Indigenous people’s exposure to social exclusion, discrimination and violence and their access to economic resources. These include:
• forced removal from their land and its spiritual connection;
• the systematic undermining and destruction of Indigenous family, cultural and spiritual life, including the forced removal of children;
• racism and discrimination;
• markedly poorer physical health;
• extreme legislative control and intrusion;
• exclusion from employment, education, health services and housing;
• substance abuse; and
• incarceration (Zubrick et al. 2004, 2004a)


**Outcomes**

Through the implementation of this plan, VicHealth aims to make a measurable contribution to local, state, national and international work in mental health promotion by:
• providing new evidence of the mental health benefits of social inclusion, countering discrimination and violence and improving access to economic resources. This will be achieved through specific research programs and the evaluation of funded projects and programs;
• identifying and documenting models of best practice in mental health promotion. This will be measured through the evaluation of funded projects and programs;
• increasing community understanding of the importance of obtaining and maintaining mental health. This will be measured through evaluation of communication strategies developed as components of this plan;
• developing the capacity of organisations and practitioners to implement and sustain mental health promotion activity, facilitated and evaluated through workforce development and organisational initiatives; and
• consolidating partnerships to advocate for and foster mental health promotion activity across the State. This will be measured through planning input, joint funding and shared ventures


Summary of current and planned areas of investment and activity

Addressing violence and discrimination
The Victorian Indigenous Leadership Strategy.
This program is designed to increase the skills and resources of young Indigenous people to play leadership roles in their communities and is being undertaken in collaboration with Victorian Indigenous communities and organisations and Aboriginal Affairs Victoria. It will:

- provide skills development and relationship building opportunities for Indigenous young people;
- engage Indigenous young people in civic activities in both the Indigenous and wider communities; and
- build community cohesion through improved dialogue within Indigenous communities and between Indigenous young people and the wider community.

An Indigenous imaging strategy.
This project will be developed in partnership with Indigenous leaders and will:

- provide opportunities for civic engagement, skills development and participation in group activities;
- contribute to strengthening a positive Indigenous identity;
- improve community awareness of the strengths and attributes of Indigenous communities; and
- improve community awareness of the links between discrimination and poor mental health and wellbeing in Indigenous communities.


Key points/aspects
The VicHealth Mental Health Promotion Framework (see overleaf) begins with three socioeconomic determinants of mental health that form the basis for the themes for action: social inclusion, freedom from discrimination and violence, and access to economic resources (A Plan for Action: Promoting Mental Health and Well Being 2005, page 12).

Implementation
The Framework is based on the understanding that long-term improvements in mental health are likely to be achieved by supporting sustained changes in individual skills and knowledge and in the broader environment. Accordingly, the health promotion actions are designed for implementation at a societal level (e.g. in legislation and regulatory frameworks), at an organisational level (e.g. in schools and workplaces), at a community level (e.g. by building social cohesion) and at an individual level (e.g. by building skills and resilience) (A Plan for Action: Promoting Mental Health and Well Being 2005, page 20).
Review processes
Not specified.

Outcomes to date
No outcomes data found using basic web search.

Amount of money allocated
Not specified
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3 Policies and Frameworks – Victoria
3h Strong Culture, Strong Peoples, Strong Families: towards a safer future for Indigenous families and communities 10 year plan

- Relationship stated but unclear: A Fairer Victoria 2009
- Relationship stated but unclear: Victorian Indigenous Affairs Framework - Improving the lives of Indigenous Victorians
- Relationship stated but unclear: A Fairer Victoria 2008: Strong People, Strong Communities
No clearly stated relationship with:
National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003 – 2013
Aboriginal and Torres Strait Islander Health Performance Framework
National Framework of Principles for Government Service Delivery to Indigenous Australians
National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being: 2004 – 2009
Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework
Framework for Reporting on Indigenous Disadvantage
Cultural Respect Framework for Aboriginal and Torres Strait Islander Health
Good practice framework. Policing illicit drugs in rural and remote Aboriginal and Torres Strait Islander communities
A National Framework for improving the health and wellbeing of Aboriginal and Torres Strait Islander Males
Be active Australia: a framework for health sector action for physical activity 2005-2010.
National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan 2000 – 2010
Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005 – 2008
Closing the Gap between Indigenous and non-Indigenous Australians
Australia's National Oral Health Plan 2004-2013
National Drug Strategy Aboriginal and Torres Strait Islander Peoples' Complementary Action Plan 2003-2009
Department of Human Services Aboriginal Services Plan 2008-2010
Aboriginal Cultural Competence Framework
Because Mental Health Matters: Victorian Mental Health Reform Strategy 2009-2019
A Plan for Action 2005 - 2007 Promoting Mental Health and Wellbeing
Aboriginal Child Placement Principle Guide
3h Strong Culture, Strong Peoples, Strong Families: towards a safer future for Indigenous families and communities 10 year plan

**Governance**
Victorian state government.

**ATSI involvement**
This 10 year plan was written by the Indigenous Family Violence Partnership Forum of Indigenous community representatives from the 10 regions across the State, Indigenous organisations and senior representatives from government departments. Our work grew out of our respect for Indigenous culture and history and our joint concern over the levels of violence in Victoria’s Indigenous communities (Strong Culture, Strong Peoples, Strong Families, page 4).

**Jurisdiction**
This 10 year plan operates within the wider Victorian Government and community partnership policy framework based on achieving a fairer Victoria for Indigenous Victorians (Strong Culture, Strong Peoples, Strong Families, page 19). Indigenous community roles are discussed in detail on page 12-13; State and National government roles are discussed on page 13).

**Longevity**
This plan outlines our vision for the next 10 years (Strong Culture, Strong Peoples, Strong Families, page 4). This is the second edition.

**Level of impact**
It is a living document which will guide, inform and direct joint efforts of the Indigenous community and the Victorian Government to reduce Indigenous family violence (Strong Culture, Strong Peoples, Strong Families, page 4).

**Relationship to other instruments**
The objectives of this 10 year plan are also those of other broad government strategies and together these policies aim to create an environment of cultural safety for Indigenous people (Strong Culture, Strong Peoples, Strong Families, page 19).

Victorian Government policy environment:
- Growing Victoria Together
Policies and Frameworks – Victoria

A Fairer Victoria
Victorian Indigenous Affairs Framework
Government Response to Indigenous Family Violence Taskforce Report
Integrated Family Violence Reform Strategy (unable to find online source)
Aboriginal Justice Agreement
Aboriginal Human Services Plan
Children Youth and Families Act
Wannik Education Strategy for Koorie students
A Way Forward – Violence Against Women Strategy
Victoria’s plan to improve outcomes in early childhood
Elder Abuse Prevention Implementation Strategy

(Strong Culture, Strong Peoples, Strong Families, page 6).

More detail is provided about the Victorian policy environment on pages 19-20.

The process also recognised that because family violence is such a broad issue, detail on related government initiatives such as child abuse, women’s safety and the accountability of perpetrators are not detailed in this plan, but are an integral part of strategies to reduce family violence (Strong Culture, Strong Peoples, Strong Families, page 12).

**Aim**

**Vision: where we are heading**

The Indigenous Family Violence Partnership Forum has a vision and guiding principles which underlies the values, achievements, objectives and actions we undertake over the next 10 years (Strong Culture, Strong Peoples, Strong Families, page 7).

**Our vision for 2018**

Families are our heart and soul. They generate dreams and values, ideals and visions for our children.

Actions and programs strengthen, honour and respect Indigenous individuals, families, communities, cultural heritage and cultural practices. We are committed to breaking the cycle of Indigenous family violence.

The Indigenous community and the Victorian Government, in partnership, will lead the development of a safer Victoria for all Indigenous families and communities (Strong Culture, Strong Peoples, Strong Families, page 7).

**Strong Culture, Strong Peoples, Strong Families** enables a strategic approach to address Indigenous family violence. It sets out a journey for the next decade –
destinations to reach (objectives), paths to take (strategies) and steps to take towards these destinations (actions) (Strong Culture, Strong Peoples, Strong Families, page 26).

**Rationale**

Victoria’s 30,000 Indigenous people are the inheritors and custodians of many diverse Indigenous cultures of Australia. These cultures survive today in differing forms in Victoria’s Indigenous communities in their various urban, regional and rural settings as expressions of both the resilience of Indigenous traditions and Indigenous peoples community (Strong Culture, Strong Peoples, Strong Families, page 10).

Indigenous children in Victoria are born into a broad community of care that consists of immediate family, Elders, extended family and the local community.\(^{44}\) In spite of the level of disadvantage, the Indigenous community is vibrant and actively seeking to address the issues that they face community (Strong Culture, Strong Peoples, Strong Families, page 10).

Notwithstanding the strong leadership demonstrated by the Indigenous community, significant investment by the Victorian Government and the fact that the majority of Indigenous families are loving and supportive, family violence in the Indigenous community remains a major challenge community (Strong Culture, Strong Peoples, Strong Families, page 10).

The Victorian Indigenous Family Violence Taskforce estimated that: ‘One in three Indigenous people are the victim, have a relative who is a victim or witness an act of violence on a daily basis in our communities across Victoria community (Strong Culture, Strong Peoples, Strong Families, page 10).

In response to the unique historical context in which family violence occurs, the Indigenous community has called for a holistic approach to family violence that addresses the legacy of the past and seeks to heal individuals, families and communities. There is a shared recognition between the Victorian Government and the Indigenous community that solutions to family violence lie within Indigenous communities themselves and that Indigenous people must lead the strategy which will prevent and eliminate family violence in the Indigenous community (Strong Culture, Strong Peoples, Strong Families, page 10).

\(^{44}\) Many Indigenous children have an Indigenous and non-Indigenous parent. See also footnote 9 regarding relationships between Indigenous and non-Indigenous people in Victoria.
Outcomes

Objectives
The objectives of the Indigenous family violence 10 year plan have been shaped by the Indigenous Family Violence Partnership Forum to frame the actions which can prevent and eliminate family violence

1. Cultural Safety: Make Victoria a safer place for all Indigenous Victorians
2. Healthy Families: Support strong, robust and healthy families that provide a safe nurturing environment
3. Education, Awareness, Prevention: Intervene early to improve education, awareness and prevention of family violence
4. Safety for Victims: Increase the safety of Indigenous families and individuals, especially women and children
5. Accountability: Increase the accountability and personal responsibility of perpetrators of family violence within Indigenous communities
6. Healing: Increase opportunities for healing for victims and perpetrators
7. Service Capability: Increase the cultural competency and capacity of the service system to improve responses to Indigenous family violence

(Strong Culture, Strong Peoples, Strong Families, page 26)

Each objective has specific strategies and actions outlined from page 29-44)

Key points/aspects

Guiding principles
To guide all elements of the plan towards the vision, the Indigenous Family Violence Partnership Forum established nine principles for developing and implementing policies and programs:

1. Family violence is not part of Indigenous culture
2. Complex nature of family violence within Indigenous communities
3. Indigenous culture
4. Partnership, transparency and accountability
5. Adequate resources
6. Empowering Indigenous communities
7. Local solutions to local problems
8. Holistic healing approach to family violence in Indigenous communities
9. Early intervention, prevention and education

(Strong Culture, Strong Peoples, Strong Families, page 8)

The Guiding Principles have equal status to and should be read in concert with the Victorian Integrated Family Violence Reform Strategy Principles (see Appendix 1 of
Through these principles, the Victorian Government acknowledges that due recognition and respect will be given to the unique knowledge, skills and expertise which Indigenous people bring to the service system.

Values
The Indigenous Family Violence Partnership Forum has identified seven clear Values for preventing and eliminating family violence (six of these mirror those developed by the Indigenous Family Violence Taskforce). These values are:
- Safety and security for victims of violence
- Strong community leadership and positive role models
- Shared responsibility and support for one another
- Healthy lifestyles, harmonious relationships and respect for self and others
- Cultural integrity/respect and cultural safety within Indigenous and mainstream services
- Healing for victims and perpetrators, and
- No more violence – in the home, in the family, in the community or in the workplace.

These values guide the plan (Strong Culture, Strong Peoples, Strong Families, page 9)

Implementation
Indigenous Family Violence Regional Action Groups have a leadership role in implementing community-led responses that educate, prevent, reduce and respond to family violence in the Indigenous community. These groups are an inclusive mechanism for the Victorian Indigenous community to develop local responses to family violence matters, ensuring they are responsive and culturally relevant to Indigenous individuals, families and communities (Strong Culture, Strong Peoples, Strong Families, page 12).

As recommended in the taskforce report and by the Partnership Forum, the community-led approach is the agreed implementation model under the Indigenous Family Violence Strategy and specifically for this plan. This includes a core role for the Partnership Forum and the Indigenous Family Violence Regional Action Groups in the implementation planning process, review and further development of this plan (Strong Culture, Strong Peoples, Strong Families, page 12).

The Partnership Forum remains the key mechanism for an ongoing partnership between Indigenous communities and the Victorian Government in implementing and reviewing the actions and strategies contained in this plan (Strong Culture, Strong Peoples, Strong Families, page 12). There are a number of other Indigenous organisations and representative frameworks which include the Regional Aboriginal Justice Advisory Committees, the Regional...
Aboriginal Services Reference Groups and, in some instances, the Local Aboriginal Education Consultative Groups. As Local Indigenous Networks and Regional Indigenous Councils are established, these groups will also play an important role in coordinating effort across sectors, particularly at a regional level (Strong Culture, Strong Peoples, Strong Families, page 12).

Pages 12-13 have more detailed discussion of functions and tasks of Indigenous groups.

**Review processes**

Achievement of these objectives requires partnership approaches between Indigenous communities, the Regional Action Groups and the Victorian Government supported by investment in both improved, integrated responses and in prevention activities. The objectives of this broader strategic plan will be advanced by implementation plans reviewed by the Partnership Forum using measures of success that monitor the extent to which these objectives are being met over time. This will include periodic independent evaluation (Strong Culture, Strong Peoples, Strong Families, page 26).

**Outcomes to date**

Page 23 has a chart which shows the achievements to date since the introduction of the Victorian Indigenous Family Violence Strategy.

**Amount of money allocated**

Not specified.
Aboriginal Child Placement Principle Guide
No clearly stated relationship with:

National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003 – 2013
Aboriginal and Torres Strait Islander Health Performance Framework
National Framework of Principles for Government Service Delivery to Indigenous Australians
National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being: 2004 – 2009
Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework
Framework for Reporting on Indigenous Disadvantage
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Good practice framework. Policing illicit drugs in rural and remote Aboriginal and Torres Strait Islander communities
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Be active Australia: a framework for health sector action for physical activity 2005-2010.
National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan 2000 – 2010
Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005 – 2008
Closing the Gap between Indigenous and non-Indigenous Australians
Australia's National Oral Health Plan 2004-2013
National Drug Strategy Aboriginal and Torres Strait Islander Peoples' Complementary Action Plan 2003-2009
Victorian Indigenous Affairs Framework - Improving the lives of Indigenous Victorians
A Fairer Victoria 2009
A Fairer Victoria 2008: Strong People, Strong Communities
Department of Human Services Aboriginal Services Plan 2008-2010
Aboriginal Cultural Competence Framework
Because Mental Health Matters: Victorian Mental Health Reform Strategy 2009-2019
A Plan for Action 2005 - 2007 Promoting Mental Health and Wellbeing
Strong Culture, Strong Peoples, Strong Families: towards a safer future for Indigenous families and communities 10 year plan
Policies and Frameworks – Victoria

3i Aboriginal Child Placement Principle Guide

Governance
Victorian State Government

ATSI involvement
- This guide was written by Rodney Monohan with assistance from the Department of Human Services, Indigenous Initiatives Unit team
- Artwork by Joanne Honeysett. Joanne is a Taungurung woman from North Eastern Victoria

Jurisdiction
To assist workers in Child Protection and Placement Services to provide a culturally appropriate and effective response to Aboriginal children and young people who need to be placed out of home.

Level of impact
Guiding.

Relationship to other instruments
This guide has been designed to sit alongside the new Protocol between the Department of Human Services' Child Protection Service and the Victorian Aboriginal Child Care Agency 2002, and to assist workers in Child Protection and Placement Services to provide a culturally appropriate and effective response to Aboriginal children and young people who need to be placed out of home.

The Convention on the Rights of the Child, adopted by the United Nations in 1989 and ratified by Australia, sets out the undertakings of the international community in recognising children as independent persons with their own integrity and human rights. The Convention refers to the best interests of the child being the primary consideration when government intervenes in family life, and to the government respecting and providing support for the responsibilities, rights and duties of parents, extended family or where applicable, the community. The convention states that children have a right to an identity; young people who are capable should be able to speak for themselves in
matters that effect them; Indigenous children shall not be denied the right, in community with other members of the group, to enjoy their own culture; and that attention shall be paid to the cultural background of children in out-of-home care (Aboriginal Child Placement Principle Guide, page 5).

**Aim**
The objectives of the Principle are to ensure that, recognition is given to an Aboriginal child’s right to be raised in their own culture and, to the importance and value of family, extended family, kinship networks, culture and community in raising – ‘growing up’ – Aboriginal children (Aboriginal Child Placement Principle Guide, page 3).

**Rationale**
The *Aboriginal Child Placement Principle Guide* was developed from issues highlighted in consultations undertaken by the Department of Human Services to review the operation of the 1992 Protocol between the Victorian Aboriginal Child Care Agency (VACCA) and the Child Protection Program within the Department of Human Services (Aboriginal Child Placement Principle Guide, page 2).

The purpose of the Aboriginal Child Placement Principle is to enhance and preserve Aboriginal children’s sense of identity as Aboriginal, by ensuring that Aboriginal children and young people are maintained within their own biological family, extended family, local Aboriginal community, wider Aboriginal community and their Aboriginal culture (Aboriginal Child Placement Principle Guide, page 3).

**Outcomes**
This principle governs the practice of Child Protection workers when placing Aboriginal children and young people in out of home care. The Aboriginal Child Placement Principle accepted and endorsed by the Secretariat of National Aboriginal and Islander Child Care (SNAICC) states that:

1. Removal of any Aboriginal child from their community and family environment by any welfare or government authority or other persons must be a last resort.
2. In the event, after consultation with a community controlled Aboriginal welfare organisation, of separation or removal of a child from its family being unavoidable then the courts or authorities will have regard to the direction of the Aboriginal Child Care Agencies and the following criteria:
   a) The child must be placed within the extended family or relatives.
   b) If the above is not feasible or possible after consultation with the community’s child/ welfare organisation, the child may be placed with:
i. an Aboriginal family from the local community and within close geographical proximity to the child’s natural family;

ii. as a last resort the child may be placed, after consultation with the local ACCA, with a non-Aboriginal family living in close proximity to the child’s natural family;

iii. any non-Aboriginal placement must ensure the maintenance of the child’s culture and identity through contact with the child’s community.

The Social Welfare Administrators, in their report on Aboriginal Fostering and Adoption, have adopted the following Child Placement Principle:

When a child is to be placed outside his/her natural family then the order of priority of placement should be:

1) A member of the child’s extended family.

2) Other members of the child’s Aboriginal community who have the correct relationship with the child in accordance with Aboriginal customary law.

3) Other Aboriginal families living in close proximity.

This order of priority of placement is to be followed in the absence of good cause to the contrary at all times.


**Key points/aspects**

The Principle defines the process of ensuring that, Aboriginal community representatives are consulted and involved in the decision making regarding the care arrangements for Aboriginal children and young people. Specific attention is paid to Aboriginal children and young people, who are separated or removed from their biological family (Australian Child Placement Principle Guide, page 3).

The Aboriginal Child Placement Principle also supports the importance of increased and ongoing involvement and control by Aboriginal people in Aboriginal child and family welfare and child protection matters (Australian Child Placement Principle Guide, page 3).

**Implementation**

The ACSASS provider VACCA or MAC and the Department of Human Services will measure compliance with the Principle, using both the Client and Service Information System (CASIS) and the Funded Agency Client Transaction System (FACTS) data collection systems (Australian Child Placement Principle Guide, page 11).

**Review processes**

Not specified.
Outcomes to date
Not specified.

Amount of money allocated
Not specified.
Additional Frameworks
National Aboriginal Health Strategy 1989

National Aboriginal Health Strategy 1989

- Approaches built on by: National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003 – 2015
- Approaches built on by: National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Well Being: 2004 – 2009

- Unclear relationship stated by: Australia’s National Oral Health Plan 2001-2013
- Unclear relationship stated by: Cultural Respect Framework for Aboriginal and Torres Strait Islander Health

- Principles guide: Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005 - 2008
- Principles guide: Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework
No clearly stated relationship with:

Aboriginal and Torres Strait Islander Health Performance Framework
National Framework of Principles for Government Service Delivery to Indigenous Australians
Framework for Reporting on Indigenous Disadvantage
Good practice framework. Policing illicit drugs in rural and remote Aboriginal and Torres Strait Islander communities
A National Framework for improving the health and wellbeing of Aboriginal and Torres Strait Islander Males
Be active Australia: a framework for health sector action for physical activity 2005-2010.
National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan 2000 – 2010
Closing the Gap between Indigenous and non-Indigenous Australians
Victorian Indigenous Affairs Framework - Improving the lives of Indigenous Victorians
A Fairer Victoria 2008
A Fairer Victoria 2008: Strong People, Strong Communities
Department of Human Services Aboriginal Services Plan 2008-2010
Aboriginal Cultural Competence Framework
Because Mental Health Matters: Victorian Mental Health Reform Strategy 2009-2019
A Plan for Action 2005 - 2007 Promoting Mental Health and Wellbeing
Strong Culture, Strong Peoples, Strong Families: towards a safer future for Indigenous families and communities 10 year plan
Aboriginal Child Placement Principle Guide
References


Australian Health Ministers’ Advisory Council’s Standing Committee on Aboriginal and Torres Strait Islander Health Working Party (Comprising the Northern Territory, Queensland and South Australia), 2004, *AHMAC Cultural Respect Framework for Aboriginal and Torres Strait Islander Health, 2004 – 2009*. Department of Health, South Australia.


Department of Planning and Community Development, *Victorian Government Indigenous Affairs Report 2006/07*, Aboriginal Affairs Victoria, Department of Planning and Community Development, Victoria.


NSFATSIH (*National Strategic Framework for Aboriginal and Torres Strait Islander Health*): *Framework for action by Governments*, NATSIHC, Canberra.


Standing Committee on Aboriginal and Torres Strait Islander Health, *Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework*, AHMAC, Canberra, 2002.


References


National Framework for improving the health and wellbeing of Aboriginal and Torres Strait Islander Males:


| Appendix 1: Poster used to advertise the first round of community consultation | 285 |
| Appendix 2: Invitation to second round consultation | 286 |
| Appendix 3: Summary Report for Community Consultation | 287 |
| Appendix 4: Mapping relationships between the policies | 307 |
| Appendix 5: 9 Principles from National Strategic Framework ATSI Health, 2003-2013 | 315 |
Appendix 1: Poster used to advertise the first round of community consultation

**TALKING IT UP!**

What makes a difference to your health?
What are the issues that people need to hear about?
– use your voice and talk it up!

When? Tuesday June 9, starting at 10am
10.30 – Cultural blessing
11am – Talking about health
12pm – Lunch
1-3pm – Group discussions

Where? Maya Healing Centre, Rossmoyne Street, Thornbury

Who? The Healing Stories team will be here to listen to anyone who wants to TALK IT UP!

Why? The findings from these group discussions and others across the local Aboriginal community will be taken to VicHealth and used in reports to argue for better Aboriginal health.

What? Take part in group discussions, be a part of the research project.

Please talk to Aunty Shirley if you have any questions about Talking it Up or the group discussions.
Appendix 2: Invitation to second round consultation

Thank you for taking part in Talking it Up!

Thank you for participating in the first consultation round of the Talking it Up Project. You are most welcome to attend the second consultation round to see and hear what has been done about the findings of the project so far and share your ideas about what needs to be reported and recommended in the report to VicHealth. We are inviting everyone who took part in the group discussions to come back together for a second round of community consultation.

Please join us for a second round of community consultation.

**Program**
10.00am: Welcome.
We will start with morning tea and we will then have a couple of hours building on the findings of the project so far, sharing information from the research and listening to your ideas about what the project should say. We will finish at lunchtime.
12pm: Lunch will be provided.

**Date:** Monday 28th September, starting at 10am

**Place:** Northlands Secondary College, East Preston

**Purpose:** This is an opportunity for you to hear about what’s been going on with Talking it Up and have your say about what gets said to VicHealth in the Talking it Up report.

RSVP to Uncle Reg Blow. If you need some help getting to Northland, please let Uncle Reg know and he will help arrange a lift for you.
Appendix 3: Summary Report for Community Consultation

Talking it Up!
Community Consultation

September 28th 2009
Questions for the second consultation with the community

Doing the research for Talking it Up has raised many questions, and we hope to discuss these ideas with the community through a second round of consultation.

Questions about policy

1. Would it be helpful to advocate for Victorian policy to show how it will integrate the past and the present, through explicitly addressing the effects of dispossession and discrimination, and provide access to the pre-requisites for health (housing, education, employment etc), as well as focusing on disease reduction?

2. Would it be helpful if Victorian health policy explicitly called for the incorporation of indigenous knowledge systems into service delivery, enabling the funding of forms of non-clinical healing services which focus on the development of consumer and community autonomy for health?

3. Would it be useful to have a voice for indigenous communities/service users in the formulation of Victorian health policy, building on the good practice that exists for some policies at national level. If so, are there existing mechanisms that could be built on, such as Local Indigenous Networks?

Questions about health service delivery

1. Would it be helpful to have standards and protocols for the delivery of non-specialised, holistic and/or non-clinical services that are explicitly based on indigenous knowledge?

2. In order to ensure access and equity in relation to service provision, would it be helpful to have data collection systems that enable the state bureaucracy to accurately determine the coverage of health services in relation to the Aboriginal population?

3. How could greater involvement of and consultation with Aboriginal people at all stages of health policy and governance be achieved? Who should take the lead in achieving this?

Questions about further collaborative community led research

1. Are there any topics, issues, problems, parts of service delivery or development that it would be useful to find out more about? For example:
   a. Services to help people make a successful transition from prison back into community?
   b. The experience of living away from country?
   c. Healing away from country?
   d. Any others…?
Other questions

1. Would it be helpful to have an organisation, such as VicHealth, lead the way by brokering conversations about the ‘elephant in the room’ (the reported ‘shunning’ of some people by some services within the Aboriginal Controlled Health sector, resulting in inequitable access to services and supports and/or poor treatment)? Is VicHealth the right organisation?

2. Would it be helpful to advocate for community and service provider education in relation to culturally safe and healthy environments for Aboriginal people (including education for policy actors and those in the health system responsible for the provision of health and healing services)?

3. Would it be helpful to advocate for the inclusion of Aboriginal health within health and allied health courses taught in all Victorian education institutions, and

4. Would it be helpful if community education around the racism that Aboriginal people historically and currently experience was provided? Who could best do this, how and where?

Priorities and taking this forward

For those items that are supported as helpful/useful, which are the most important and which should be tackled first?

What should be done by whitefellas, what by blackfellas, and what in partnership? (This question applies to each of the items that are supported as helpful/useful)
Part 1: Talking it Up with the community

Findings

Emergent themes have been arranged into four groups, which are discussed in turn:

1. Effects of the past in the present
2. Identity and voice
3. Service quality and gaps in provision
4. Promoting healing
5. Warriors and tiddas

The fifth theme winds its way throughout the other four themes, but has been selected out for separate comment. The separate experiences of men and women, their interpretation and the meaning each gender group placed on them are worthy of comment, and in keeping with the ‘men’s business’ and ‘women’s business’ structure of the forums.

This section of the report concludes with a consideration of the relationships between these themes, which forms the basis for an emergent theory of urban Aboriginal health from the perspective of Aboriginal people living in the metropolitan area.

1. Effects of the past in the present

a) Sickness is everywhere

*There’s so much hopelessness ... what's the use*
*People are sick with worry*

Sickness is everywhere: individuals, families, and communities are all sick. It is a hard way to live, and hard to know how to heal oneself and others. Alcohol, drug addiction and violence are responses to the frustration and hopelessness. This perpetuates, or creates, an intergenerational aspect, which is mutually reinforced by current policies, e.g. child protection.

b) The family is the site for sickness and healing

*We need to focus on healing and looking after each other, so you don’t get bitter about how dysfunctional things are*
*Men and women are both unwell – why aren’t we helping each other instead of fighting all the time?*

The family is the site for sickness, and also contains the possibility for healing. For this to happen, strategies and supports for people to identify with, and connect to, culture, land (home) and community are needed.
c) Lack of respect and its connection to ill health

*How do I find ways of feeling good about myself?*
*Whitefellas always looking down their nose at us*

Lack of respect, experienced personally and communally, within communities, within families, and between black and white Australians, is strongly connected to ill health and an inability to heal.

d) Dispossession is linked to ill health

*Blackfellas need their land*
*The dreamtime was love, peace and justice…this is gone for blackfellas*

The effect of dispossession, and its linkage to ill health, needs to be understood at personal, infrastructural, and legal levels. At the personal level, the loss of land (and therefore culture) impact on self-esteem and mental health, and is linked to poor choices which perpetuate dysfunctional life circumstances. At the infrastructural level, a lack of housing and support services (in particular, services for people in and leaving jail, and for women fleeing family violence) contribute to an ongoing experience characterised by rootlessness, instability and transience. At the legal level, the lack of real land rights, the failure of native title in Victoria, and difficulties with proving aboriginal identity mean that basic structures for well-being are lacking.

e) Living in ‘no man’s land’ affects health

*If you’re born in the city, how can you ever connect to land, smell the gum trees?*
*I get condemned if I go to someone else’s country…*

Dispossession has left Aboriginal people trapped in a kind of no man's land, where, to function in the mainstream economy, they often have to leave their country, but then find themselves in somebody else's country without proper protocols for establishing themselves. Finding a 'home ground' in a strange land is a key part of being able to flourish in contemporary society.

f) The build up of past and present racism

*I grew up in a time when you needed a ticket to go off the mission land*
*For me as a worker to be treated like that in a public hospital, I was disgusted*
Experiences of racism carry forward from the past, and exist independently in the present, with a compounding affect. The impact of growing up with constant, overt discrimination has a massive impact on individual identity and self-esteem, leaving people feeling that they would "never be good enough", only ever be "second-place", having "no place or role". Contemporary and continued experiences of racism, especially those felt within the service system, leave people feeling degraded and worthless. This has an impact on people's ongoing engagement with services.

2. **Identity and voice**

a) **Loss of cultural identity and role**

*You had your place in the law and in the family*

In the past, culture provided people with a role, place and social system that allowed them to flourish as families and communities, including processes for dealing with events that disrupted the social fabric. For many people who now live in an urban area, this has disappeared within a generation. For the men (for whom this appeared to be particular important), this was portrayed through nostalgia for an idyllic past, which they set against descriptions of a dysfunctional present.

b) **Feeling invisible**

*We are treated like children in our own country*

*There’s nobody out there to listen to us, because everyone knows everything*

Aboriginal people feel invisible in their own country. This has a number of dimensions. Firstly, they feel that what they have to offer (e.g. in regards to sustainable treatment of water and land) is ignored. Secondly, despite the perpetuation of age-old problems, they have no voice in policy which affects the health and well-being, despite having valuable knowledge in relation to the problems and their solutions. Finally, they are at a loss to understand what they need to do to get listened to.

c) **Loss of voice is about loss of respect, and vice versa**

*Health is a big industry ... aboriginal people are perfect clients*

*And then, as you got older, we started thinking about taking responsibility and who you wanted to be, making a spear, a boomerang*
Having a voice and being respected are connected. They talk about the ways in which they have been problematised and commodified, as "dysfunctional clients", a disempowered and disempowering position in which other 'experts' come and 'know about' and 'do things to' them. There is the sense that they risk becoming identified with a pathology e.g. sexual assault, drug and alcohol, violence, or criminality. Counter to this is a view of themselves as guardians of the land and holders of knowledge, both in relation to the environment, and in relation to healing their own communities.

d) The invisibility of urban Aboriginal people

Tourists get told we’re not blackfellas…well, what are we?
We got people out there that say they’re black, but they’re not black…they’re taking the system for a ride

As urban Aboriginal people, perhaps with pale skins, they feel particularly invisible. This is reflected in the repeated difficulties of proving Aboriginality and in the feelings of rejection that come with not being counted.

e) The need for a new story to be accepted

I could kill everybody all of the time – it’s just not healthy
People didn’t want to hear the bad stories, just the nice feeling stuff – it’s important to hear the impact the past has had on people

A return to visibility would involve recognition of past wrongs and an acknowledgement of history on their terms, as well as effective mechanisms for representation. Men associate unfair treatment within the legal system, both historically and currently, with powerlessness and frustration. They feel let down by the legal system, and not sure where how to get redress. Combined with the overt racism that they have experienced, this is a strong feature in their description of their own poor health, violent reactions to their invisibility and recourse to drugs and alcohol.
3. Service quality and gaps in provision

a) Service system problems

What I really need is a carer where I live, someone to keep an eye on me and speak on my behalf. Coz I dunno what to say half the time on my behalf. I leave home to go to the doctor's surgery. By the time I get to the doctor's surgery I'm in another world, know what I mean?

More [healing] circles…I believe that everyone has a voice and that through times gone by our voice has been…stopped. These circles are imperative for us to get stronger and listen to and hear each others stories

Women, in particular, focused on problems within the service system, and what is needed to fix it. There are two key areas for service development. The first of these relate to social services, in particular, family violence and housing, and services for people in and coming out of prison. Integrated services, particularly those which have a mental health dimension, are important. It is important that service design and staffing are capable of responding to the complexity and multi-dimensionality of experiences and issues that people have. The second area relates to cultural services, those which build understanding and recognition of aboriginal culture, within aboriginal and mainstream organisations, as well as services direct to families. These might include support for families to take trips to country with the purpose of building culture with their children, and support for travel to funerals.

b) The need for service models which draw on indigenous knowledge systems

We know what the problems are, because we've experienced them – we know what needs to be changed to make things better

Women need to talk about it, what they've been through – not bear it alone

There needs to be a focus on preventative services, including child care and women's programs, and programs to teach people how to stay out of prison. Participants in the women's group talked about the need for service models which draw on communities' knowledge (for instance, strengths-based approaches). The women also questioned the competencies required to work with people who had experienced complex and entrenched disadvantage. They recognised the precarious position of relying on workers from the communities in question, with their expert and first hand knowledge of the problems that service users face, and the need to ensure that those same workers were supported in their own healing journeys.

c) Inequitable access to services: the ‘elephant in the room'

An industry has been made out of our misery

There is a lot of discrimination…even in our own orgs…they can get a bit toffee, not compassionate enough
The major issue in relation to service provision and quality, however, concerned divisions within the Aboriginal population in Victoria, where some people found themselves unable to access particular services, despite being eligible. In the words of one participant, ‘there is a division in the community between the rich black bureaucrats and the little group that are suffering down there’. This phenomenon is closely related to nepotism in the non-Aboriginal community. One female elder described this as the act of ‘shunning’, where one individual or family will ‘shun’ or turn their backs on another, leaving them out of the circle through which Aboriginal business, including healing, can be done. Examples of shunning included discrimination towards some individuals and families, depending on who is on the board or staff of the service providing organisation. It covers difficulties with proving aboriginality. And it raises questions about where do people go when they are turned away from these organisations. The discrimination from within the community is felt all the more painfully, and whilst it is clear that it needs to stop, is not clear how this is going to happen. Because of the difficulties of discussing this experience with actors in the service systems, it can be regarded as ‘the elephant in the room’ of Aboriginal services.

4. Promoting healing

a) Talking and listening as acts of healing

*Healing is about having someone to talk to, so that you can feel you’re important to someone*

*Women need to stick together and remain proud of their families, despite the violence and death*

Healing and well-being were not expressed in relation to curing disease, but in terms of having a voice to talk to each other, the healing experience of being listened to, and feeling cared for. Talking is central to the healing process. Talk and sharing experience are seen as acts of healing, active experiences that are constitutive and productive. Talk is the carrier and shaper of culture, it is a means of showing care for self and others, and thus a means of healing individually and communally.

b) The importance of being in control

*We’d like people to look at Aboriginal systems of living and environment, and learn from that*

*The importance of spiritual continuity – even if we are physically changed*

A second aspect of healing was about feeling in control of their own lives, through the provision of services in which they had a say, and the means of being represented in decision-making at all levels of governance.
c) Dialogue and reparation

*We have a strong knowledge base here*

*We could be included and respected for our input into debates*

Dialogue is seen to be important as a means of reparation and progress, and is the means of bringing together talk and control. Dialogue is needed at a range of levels: interpersonal, family and community, between different aboriginal communities and between aboriginal and non-aboriginal communities. Dialogue needs to occur within a recognised set of structures, which would include a treaty and a system of representation linked into broader governance arrangements. In particular, women expressed the desire for a voice of their own, recognising their strength in numbers, and expressing their desire for control of their own resources.

5. Warriors and tiddas

Whilst the themes were common to both men and women, there were differences in their expression, emphasis and interpretation. The men, who referred to themselves as ‘warriors’, showed greater concern with the loss of their traditional role as protector of family and land, and that the impact of this cultural dispossession had on their health and well-being. The women called themselves ‘tiddas’ (sisters), and talked largely about what was needed to support and protect their families.

This appears to reflect a shift in the protector/guardian role from men to women, a cultural disruption which is damaging for both genders. The men were able to offer an analysis that centred on their double dispossession, first by the failure of modern urban society to ‘reconstruct’ a role for them, and secondly by the loss of their role to their women. The women didn’t talk in terms of their liberation from their traditional role, but about the heavy burden of this shift, which required them to care for their men as well as their families, in order to carry their cultural traditions forward for future generations.

This leads to the need for spaces in which Aboriginal men can talk to and share their experiences with each other, and likewise, spaces where Aboriginal women can talk to each other. The women, in particular, articulated the need for a representational voice to ensure that women’s experiences and issues are included in broader governance structures. The women talked about the link between family violence and loss of voice, which made it ‘hard to find my way out’. Women did not turn their backs on the men who were violent, but talked about their need to have separate, safe spaces in which they could share their experiences and regain their self-respect and pride in their culture and who they are.
Relationship between the themes

The table overleaf suggests the interconnections between the emerging themes. Themes have been grouped into two main strands: those which relate to the factors impacting on health and well-being, and those which relate to interventions that promote healing.

The factors that impact on health and well-being are causative and cumulative, resulting in widespread, even ubiquitous, sickness.

The interventions to promote healing are related to the various factors impacting on health and well-being, and combine to suggest an integrated approach to health and healing for Aboriginal people which addresses the concrete and symbolic aspects of their lives.
Part 2: Literature Review

What are the policy implications of existing research around health and health promotion for urban Aboriginal communities?

**Equality and difference**
- Remedialism, bringing Aboriginal people ‘up’
- Over-emphasis on bio-medical indicators, lack of holism
- Recognition of unique and ‘good’
- Homogenisation of Indigenous identities

**Reconciliation and history**
- Context: historical, social and cultural
- Reconciliation and history
- Legacy of colonisation

**Culturally appropriate policy**
- Plans agreed by Aboriginal people
- Collaboration
- Identifying people as Aboriginal

**Social structures and inequities**
- Poverty and powerlessness
- Social determinants
- Social structures and inequities

**Policy making and doing**
- Policy vs practice
- Engagement with Aboriginal communities
- Consultation & partnerships
- Evaluation & research
- Workforce & implementation

**Equality and difference**
- Equality and difference
- Self determination

**Collaboration**
- Accountability & transparency
- Use & mis-use of data

**Social determinants**
- Over-emphasis on bio-medical indicators, lack of holism
- Poverty and powerlessness

**Recognition of unique and ‘good’**
- Context: historical, social and cultural

**Homogenisation of Indigenous identities**
- Collaboration

**Self determination**
- Policy vs practice
- Workforce & implementation

**Legacy of colonisation**
- Evaluation & research

**Racialisation and history**
- Context: historical, social and cultural

**Collaboration**
- Accountability & transparency
- Use & mis-use of data

**Culturally appropriate policy**
- Plans agreed by Aboriginal people
- Collaboration
- Identifying people as Aboriginal

**Social structures and inequities**
- Poverty and powerlessness
- Social determinants
- Social structures and inequities

**Policy making and doing**
- Policy vs practice
- Engagement with Aboriginal communities
- Consultation & partnerships
- Evaluation & research
- Workforce & implementation
Part 3: Policy Review

Policy analysis: national and state policies, frameworks and strategies that inform or govern Aboriginal health in Victoria

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<tbody>
<tr>
<td>Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework</td>
<td>Framework for Reporting on Indigenous Disadvantage</td>
<td>Cultural Respect Framework for Aboriginal and Torres Strait Islander Health</td>
<td>Good practice framework. Policing illicit drugs in rural and remote Aboriginal and Torres Strait Islander communities</td>
</tr>
</tbody>
</table>

Rows 1-4 are National policies, frameworks and strategies
Rows 5-6 are Victorian policy and frameworks
Is there clearly documented Aboriginal participation and/or consultation in the development of the policy or strategy?

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</tr>
</tbody>
</table>

Rows 1-4 are National policies, frameworks and strategies
Rows 5-6 are Victorian policy and frameworks
Darker shading = more, formalised participation
# How is Aboriginal participation and/or consultation specified in the policy document?

<table>
<thead>
<tr>
<th>Row</th>
<th>Description</th>
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<tbody>
<tr>
<td>1</td>
<td>Prepared by the National Aboriginal and Torres Strait Islander Health Council for the Australian Health Ministers' Conference</td>
</tr>
<tr>
<td>2</td>
<td>Developed by the Standing Committee on Aboriginal and Torres Strait Islander Health</td>
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<tr>
<td>3</td>
<td>Not specified.</td>
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<tr>
<td>5</td>
<td>The Aboriginal and Torres Strait Islander Health Workforce Working Group is charged with planning, implementation, coordination and monitoring</td>
</tr>
<tr>
<td>6</td>
<td>Consulted widely with Indigenous organisations, governments and researchers. The insights gained from Aboriginal and Torres Strait Islander people will be reflected in the next report.</td>
</tr>
<tr>
<td>7</td>
<td>Widespread consultation.</td>
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<td>8</td>
<td>Not specified.</td>
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<tr>
<td>9</td>
<td>National Aboriginal and Torres Strait Islander Health Workforce Working Group is charged with planning, implementation, coordination and monitoring</td>
</tr>
<tr>
<td>10</td>
<td>Based on consultations with Aboriginal and Torres Strait Islander stakeholders</td>
</tr>
<tr>
<td>11</td>
<td>Many organisations and individuals have made valuable contributions to the development of the Strategy and Action Plan, including Aboriginal and Torres Strait Islander nutrition workforce; NACCHO; and ATSIC</td>
</tr>
<tr>
<td>12</td>
<td>Monitoring and evaluation will also require adequate consultation and involvement of Aboriginal Torres Strait Islander people.</td>
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<tr>
<td>13</td>
<td>Not specified.</td>
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<tr>
<td>14</td>
<td>Government needs to involve Indigenous people in the design and delivery of programs locally and regionally, and share responsibility for outcomes.</td>
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<tr>
<td>15</td>
<td>Not specified.</td>
</tr>
<tr>
<td>16</td>
<td>The Aboriginal and Torres Strait Islander Peoples' Reference Group was established to negotiate the development of this action plan</td>
</tr>
<tr>
<td>17</td>
<td>Forums will in future involve... ongoing representation of Aboriginal communities.</td>
</tr>
<tr>
<td>18</td>
<td>Would not have been possible without contributions from Aboriginal signatory organisations, a range of staff in Aboriginal Community Controlled Organisations, through regional Aboriginal advisory groups and through individual consultations</td>
</tr>
<tr>
<td>19</td>
<td>Not specified.</td>
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<tr>
<td>20</td>
<td>Victorian Aboriginal Child Care Agency (VACCA) was commissioned.</td>
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<tr>
<td>21</td>
<td>Not specified.</td>
</tr>
<tr>
<td>22</td>
<td>An Indigenous people advisory group.</td>
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<tr>
<td>23</td>
<td>Not specified.</td>
</tr>
<tr>
<td>24</td>
<td>Written by the Indigenous Family Violence Partnership Forum of Indigenous community representatives and Indigenous organisations</td>
</tr>
<tr>
<td>25</td>
<td>Written with assistance from the Department of Human Services, Indigenous Initiatives Unit team.</td>
</tr>
</tbody>
</table>

Rows 1-4 are National policies, frameworks and strategies
Rows 5-6 are Victorian policy and frameworks

Darkest shading = formalised participation in developing or writing the policy
Mid-shading = community consultation or advisory groups
Lightest shading = proposes participation
National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003 - 2013

- Approaches are built on: Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005 - 2008
- Evaluation tool: Aboriginal and Torres Strait Islander Health Performance Framework
- Quantitatively measured by: Aboriginal and Torres Strait Islander Health Performance Framework
- Principles guide: Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework
- Principles guide: Cultural Respect Framework for Aboriginal and Torres Strait Islander Health
- Principles guide: Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005 - 2008
- Shares priority areas: COAG Reconciliation Framework
- Shares priority areas: Aboriginal and Torres Strait Islander Health Performance Framework
- Shares priority areas: A National Framework for improving the health and wellbeing of Aboriginal and Torres Strait Islander Males

- Builds on approaches in this document: National Aboriginal Health Strategy 1989
- Implementation plan of framework: Victorian Indigenous Affairs Framework
- Improving the lives of Indigenous Victorians
- Considered in the planning process of: Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework
- Included in the planning process of: Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005 - 2008
- Considered in the planning process: Framework for Reporting on Indigenous Disadvantage
- To be considered in the planning process: Framework for Reporting on Indigenous Disadvantage
## Appendix 4: Mapping relationships between the policies

### Key

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image1.png" alt="Yellow Arrow" /></td>
<td>Guided by the principles of</td>
</tr>
<tr>
<td><img src="image2.png" alt="Green Arrow" /></td>
<td>Share priority areas</td>
</tr>
<tr>
<td><img src="image3.png" alt="Red Arrow" /></td>
<td>Implementation plan of framework</td>
</tr>
<tr>
<td><img src="image4.png" alt="Blue Arrow" /></td>
<td>Quantitative measurement of framework</td>
</tr>
<tr>
<td><img src="image2.png" alt="Green Arrow" /></td>
<td>Implementation through this plan/strategy</td>
</tr>
<tr>
<td><img src="image3.png" alt="Red Arrow" /></td>
<td>To be considered/included in the planning process</td>
</tr>
<tr>
<td><img src="image5.png" alt="Yellow Circle" /></td>
<td>Related to other documents not included in this analysis</td>
</tr>
<tr>
<td><img src="image6.png" alt="Yellow Triangle" /></td>
<td>Evaluation/monitoring tool of framework</td>
</tr>
<tr>
<td><img src="image6.png" alt="Yellow Triangle" /></td>
<td>Builds on approaches in this document</td>
</tr>
<tr>
<td><img src="image7.png" alt="Red X" /></td>
<td>Relationship stated but unclear</td>
</tr>
<tr>
<td><img src="image8.png" alt="Blue Square" /></td>
<td>Potential to play a role</td>
</tr>
</tbody>
</table>
This diagram depicts the arrangement of the following pages. Note the general lack of interrelationships between the policies. The spreadsheet pages are presented in numerical order over the next six pages of the appendix.
This table indicates the connections between frameworks. Each document is listed in column A and a mark is made in the relevant document column for each document that is mentioned in this original document. The nature of the relationship is indicated using a simple key. The direction of arrows indicates the relationship:

1. Policies and Frameworks - National
   - 1a National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003 - 2013
   - 1b Aboriginal and Torres Strait Islander Health Performance Framework
   - 1c National Framework of Principles for Government Service Delivery to Indigenous Australians
   - 1d National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being: 2004 - 2009
   - 1e Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework
   - 1f Framework for Reporting on Indigenous Disadvantage
   - 1g Cultural Respect Framework for Aboriginal and Torres Strait Islander Health
   - 1h Good practice framework. Policing Illicit drugs in rural and remote Aboriginal and Torres Strait Islander communities
   - 1i A National Framework for improving the health and wellbeing of Aboriginal and Torres Strait Islander Males

2. Cultural Respect Framework for Aboriginal and Torres Strait Islander Health
<table>
<thead>
<tr>
<th>2. Guidelines and strategies - National</th>
</tr>
</thead>
<tbody>
<tr>
<td>2a National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan 2006 - 2010</td>
</tr>
<tr>
<td>2b Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005 - 2008</td>
</tr>
<tr>
<td>2c Closing the Gap between Indigenous and non-Indigenous Australians</td>
</tr>
<tr>
<td>2d Australia’s National Oral Health Plan 2004-2013</td>
</tr>
<tr>
<td>2e National Drug Strategy Aboriginal and Torres Strait Islander Peoples’ Complementary Action Plan 2003-2009</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Policies and Frameworks - Victoria</th>
</tr>
</thead>
<tbody>
<tr>
<td>3a Victorian Indigenous Affairs Framework - Improving the lives of Indigenous Victorians</td>
</tr>
<tr>
<td>3b A Fairer Victoria 2009</td>
</tr>
<tr>
<td>3c A Fairer Victoria 2008: Strong People, Strong Communities</td>
</tr>
<tr>
<td>3d Department of Human Services Aboriginal Services Plan 2008-2010</td>
</tr>
<tr>
<td>3e Aboriginal Cultural Competence Framework</td>
</tr>
<tr>
<td>3f Because Mental Health Matters: Victorian Mental Health Reform Strategy 2005-2019</td>
</tr>
<tr>
<td>3g A Plan for Action 2005 - 2007 Promoting Mental Health and Wellbeing</td>
</tr>
<tr>
<td>3h Strong Culture, Strong Peoples, Strong Families: towards a safer future for Indigenous families and communities 10 year plan</td>
</tr>
<tr>
<td>3i Aboriginal Child Placement Principle Guide</td>
</tr>
<tr>
<td>1a</td>
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<tr>
<td>----</td>
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<tr>
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<tr>
<td></td>
</tr>
</tbody>
</table>

This table indicates the connections between frameworks. Each document is listed in column B and a mark is made in the relevant document column for each document that is mentioned in this original document. The nature of the relationship is indicated using a simple key. The direction of arrows indicates the relationship.

- National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003 - 2013
- Aboriginal and Torres Strait Islander Health Performance Framework
- National Framework of Principles for Government Service Delivery to Indigenous Australians
- National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Well Being 2004 - 2009
- Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework
- Framework for Reporting on Indigenous disadvantage
- Cultural Respect Framework for Aboriginal and Torres Strait Islander Health
- Good practice framework. Policing I illicit drugs in rural and remote Aboriginal and Torres Strait Islander communities
- A National Framework for improving the health and wellbeing of Aboriginal and Torres Strait Islander males
<table>
<thead>
<tr>
<th>Be active Australian framework for health sector action for physical activity 2005-2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Aboriginal and Torres Strait Islander Health Plan 2009 - 2010</td>
</tr>
<tr>
<td>Aboriginal and Torres Strait Islander Sexual Health and Bloodborne Virus Strategy 2005 - 2008</td>
</tr>
<tr>
<td>Closing the Gap between Indigenous and non-Indigenous Australians</td>
</tr>
<tr>
<td>Australia's National Oral Health Plan 2004-2013</td>
</tr>
<tr>
<td>National Drug Strategy Aboriginal and Torres Strait Islander Peoples' Complementary Action Plan 2003-2006</td>
</tr>
<tr>
<td>Victorian Indigenous Affairs Framework: Improving the lives of Indigenous Victorians</td>
</tr>
<tr>
<td>A Fairer Victoria 2009</td>
</tr>
<tr>
<td>A Fairer Victoria 2008: Strong People, Strong Communities</td>
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<tr>
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<tr>
<td>Aboriginal Child Placement Principle Guide</td>
</tr>
</tbody>
</table>
Appendix 5: 9 Principles from National Strategic Framework ATSI Health, 2003-2013

This National Strategic Framework is based on a commitment to nine principles:

**Cultural respect**
Ensuring that the cultural diversity, rights, views, values and expectations of Aboriginal and Torres Strait Islander peoples are respected in the delivery of culturally appropriate health services.

**A holistic approach**
Recognising that the improvement of Aboriginal and Torres Strait Islander health status must include attention to physical, spiritual, cultural, emotional and social well-being, community capacity and governance.

**Health sector responsibility**
Improving the health of Aboriginal and Torres Strait Islander individuals and communities is a core responsibility and a high priority for the whole of the health sector. Making all services responsive to the needs of Aboriginal and Torres Strait Islander peoples will provide greater choice in the services they are able to use.

**Community control of primary health care services**
Supporting the Aboriginal community controlled health sector in recognition of its demonstrated effectiveness in providing National Strategic Framework for Aboriginal and Torres Strait Islander Health appropriate and accessible health services to a range of Aboriginal communities and its role as a major provider within the comprehensive primary health care context. Supporting community decision-making, participation and control as a fundamental component of the health system that ensures health services for Aboriginal and Torres Strait Islander peoples are provided in a holistic and culturally sensitive way.

**Working together**
Combining the efforts of government, non-government and private organisations within and outside the health sector, and in partnership with the Aboriginal and Torres Strait Islander health sector, provides the best opportunity to improve the broader determinants of health.

**Localised decision making**
Health authorities devolving decision making capacity to local Aboriginal and Torres Strait Islander communities to define their health needs and priorities and arrange for them to be met in a culturally appropriate way in collaboration with Aboriginal and Torres Strait Islander health and health related services and mainstream health services.

**Promoting good health**
Recognising that health promotion and illness prevention is a fundamental component of comprehensive primary health care and must be a core activity for specific and mainstream health services.

**Building the capacity of health services and communities**
Strengthening health services and building community expertise to respond to health needs and take shared responsibility for health outcomes. This includes effectively equipping staff with appropriate cultural knowledge and clinical expertise, building physical, human and intellectual infrastructure, fostering leadership, governance and financial management.

**Accountability**
Including accountability for services provided and for effective use of funds by both community-controlled and mainstream health services. Governments are accountable for effective resource application through long-term funding and meaningful planning and service development in genuine partnership with communities. Ultimately, government is responsible for ensuring that all Australians have access to appropriate and effective health care.