AUSTRALIAN MEDICAL ASSOCIATION REPORT CARD SERIES 2009

Aboriginal and Torres Strait Islander Health

THE HEALTH OF INDIGENOUS MALES BUILDING CAPACITY, SECURING THE FUTURE

It is a tragic and all too familiar story that Indigenous males are likely to die earlier from preventable causes than non-Indigenous males and Indigenous females. Indigenous males are also more likely to experience much higher rates of preventable diseases and health conditions.

The Council of Australian Governments (COAG) has undertaken to work with Indigenous communities and others to close the gap in health and life expectancy between Indigenous and non-Indigenous Australians within a generation. However, national efforts to close the gap will not succeed without turning around the high rates of poor health and early death among Indigenous boys, adolescents and men.

The AMA believes it is important not to become overwhelmed or paralysed by the facts about the health of Indigenous males. None of it is inevitable, and it is a matter of human rights that it should not continue.

This Report Card is about positive solutions – discerning what factors contribute to ill health and early death for Indigenous males, what factors can protect against those poor outcomes, and how these influences can be managed at a national level, and within Indigenous communities, to bring about positive directions in the health of Indigenous males for the future.

The conclusion is that there is a long way to go, but there is every reason to expect that a healthy future for Indigenous boys, adolescents and men can be secured with the right support, the right partnerships, and the right opportunities for Indigenous people to empower themselves for better health. This Report Card sets out specific measures and policy options to reflect these things, including measures for expanding primary health care, enhancing culturally appropriate care in all Australian health services, local community capacity building, disease prevention, and developing opportunities for fuller economic engagement by Indigenous peoples.

Significant steps have already been taken by COAG in terms of funding some initiatives in these areas. However, the AMA still awaits a real and active commitment on the part of governments to establish genuine, long-term health partnerships with Indigenous people.

Partnerships and respect are central to achieving positive and enduring health outcomes, particularly for Indigenous males. Among the most salient of this Report Card's findings is the fact that the loss of status, self-esteem and sense of purpose experienced by many Indigenous men is intimately bound up with their poor health, as both cause and effect.

The AMA believes that all Australian men are entitled to a sense of identity, of belonging, and a sense of purpose in their lives. They deserve to feel pride in themselves, their families and their culture. The absence of these things has had profound implications for the health of Indigenous men, who may have also lost their connection to their country, language and spirit.

Improving the health of Indigenous males lies partly in them recapturing control of their lives, and the factors that determine their health and life prospects. This building of capacity, individual responsibility and control is best served when governments, and the other agencies that make decisions about health resourcing, make them collaboratively with Indigenous people in the context of a genuine partnership.

The solutions proposed in this Report Card provide key measures for addressing the poor health outcomes of Indigenous males, and they should form a central part of a long-term national plan to close the gap.

Dr Andrew Pesce
President, Australian Medical Association

Aboriginal Health painting **Jillie Nakamarra**

INDIGENOUS AUSTRALIAN MALES: DIVERSE AND RESILIENT

Indigenous males are diverse. Nearly one-quarter (24%) live in remote and very remote locations and are more likely to have access to traditional culture and homelands, but most live in major cities and inner regional areas (53%) [ABS 2007]. Indigenous males are also varied in their "spiritualities, political beliefs, economic status, sexualities and lifestyles" [Adams 2001].

Indigenous males are generally young, with a median age of 20 years in 2006 compared with 36.3 years for non-Indigenous males [ABS 2008a]. This is mainly because Indigenous men die earlier due to higher rates of illness and injury. Much of this illness and injury is avoidable. A young and diverse Indigenous male population also has resilience and the capacity to heal.

The resilience of Indigenous males is already apparent in many ways, for example:

- the declining death rates among Indigenous males (9% reduction since 1991) [AHMAC 2008],
- the overall increase in the median age of death for Indigenous males between 2000 and 2007 (with the exception of the Northern Territory) [SCRGSP 2009] and
- the reduced hospitalisation of Indigenous men for pneumonia, and for assault between 1998-99 and 2005-2006 [AHMAC 2008].

Indigenous males nonetheless experience significantly shortened life expectancy, seriously poor health and unjustifiable health inequalities from infancy through to manhood. This is a familiar and disturbing story. However, it is necessary to retell it to identify where Indigenous males need the greatest support.

THE HEALTH OF INDIGENOUS MALES ACROSS THE LIFESPAN

An Indigenous boy born in 2005-2007 can expect to die at age 67, nearly 6 years earlier than an Indigenous girl, and 11.5 years earlier than a non-Indigenous boy born at the same time [ABS 2009].

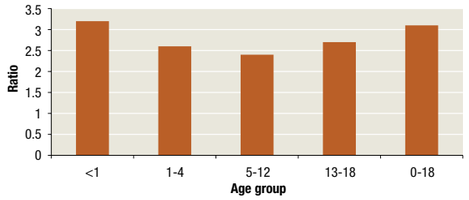
Infancy, boyhood and teenage years

Between 2005 and 2007, Indigenous boys were 1.4 times more likely to die in the first year of their lives than Indigenous girls, and nearly twice as likely to die as other infants in the general population [SCRGSP, 2009]. Deaths in the first 28 days are often related to complications of birth and pregnancy. In the following 11 months, factors such as living environments and nutrition are more relevant [AHMAC, 2008].

Indigenous boys who survived their first year were more likely to die up to the age of 4 than Indigenous girls, and were 2.6 times more likely to die than non-Indigenous boys aged 1-4 years [SCRGSP, 2009; Freemantle & McAullay, 2009]. In 2002-2006, causes of death for Indigenous children between 0-4 years included congenital malformations, injury and poisoning and respiratory, circulatory and parasitic diseases [SCRGSP, 2009]. At all age groups below 18 years in 2002-2006, Indigenous boys and teenage males died at higher rates than their non-Indigenous counterparts [Freemantle & McAullay, 2009]. Figure 1 shows the rate ratios for these age groups (RR: the Indigenous rate divided by the non-Indigenous rate).

Indigenous boys and teenagers also experience higher rates of certain health conditions than their non-Indigenous counterparts. These include diseases of the ear and hearing loss, respiratory diseases such as asthma and bronchitis, trachoma, skin conditions and parasitic diseases such as scabies [AMA, 2008]. Indigenous male children are also more likely to be hospitalised for dental care and injuries, and Indigenous boys aged 5-14, more likely to be hospitalised for mental and behavioural disorders [Jamieson et al, 2007; AHMAC, 2008; SCRGSP, 2009]

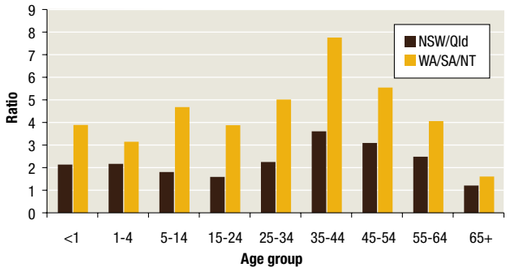
Figure 1: Indigenous:non-Indigenous death rates ratios for male children and teenagers, by age group, Qld, WA, SA and the NT, 2002-2006



Young adults and older men

Between 2005 and 2007, Indigenous men died at higher rates than non-Indigenous men at all ages (Figure 2) [ABS, 2008c].

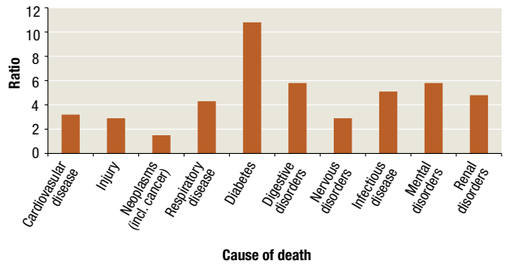
Figure 2: Indigenous:non-Indigenous male death rate ratios, by age group and jurisdiction, 2005-2007



Many of these deaths were from avoidable causes. Between 2002 and 2006, Indigenous men aged 25 – 64 died from avoidable causes at four to six times the rate of non-Indigenous men of the same age. Younger Indigenous males (15-24 years) were nearly three times more likely to die from preventable causes than their non-Indigenous counterparts [SCRGSP, 2009].

Cardiovascular disease (including heart disease and stroke) was the leading cause of preventable death among Indigenous men, and accounted for 27% of deaths between 2000-2005. This is 3.2 times the rate for non-Indigenous men [ABS & AIHW, 2008]. Injury was the next most common cause of death for Indigenous men, followed by neoplasms (mainly cancers), respiratory diseases and diabetes. Deaths of Indigenous males from respiratory disease occurred at more than four times the rate of non-Indigenous men between 2001-2005 [ABS & AIHW, 2008]. For all the major causes of death for Indigenous men, each occurred at higher rates than for non-Indigenous men (Figure 3).

Figure 3: Indigenous:non-Indigenous male mortality ratios, by selected causes of death, 2001-2005



Preventable diseases are killing young and middle-aged Indigenous men (35-54 years) and at much higher rates than non-Indigenous men of this age (at rates seven to 12 times higher in 2002-2005 for cardiovascular disease, 13 times higher for chronic lower respiratory disease, 18 times higher for influenza and pneumonia, and 31 times higher for kidney disease in the 45-54 year age group) [ABS & AIHW, 2008].

Indigenous men also had significantly higher levels of hospitalisation, at a standardised rate of 876 per 1,000 in 2007-08 compared with 358 per 1,000 for non-Indigenous males [derived from AIHW 2009]. Rates of hospitalisation due to preventable health conditions can indicate if people are receiving adequate primary health care. In 2006-07, the highest rate of admissions for chronic conditions for Indigenous males to public hospitals in Queensland, Western Australia, South Australia and the Northern Territory was for end-stage renal disease (particularly for dialysis), at a rate of 579 per 1,000 (RR 12.3), followed by circulatory diseases (RR 1.6), mental and behavioural disorders (RR 2.1), diabetes (RR 4.3) and cancer (RR 0.6) [SCRGSP, 2009]. In 2005-06, 10% of all hospitalisation for Indigenous males was because of injury, the most common cause of which was assault [ABS & AIHW, 2008].

SOCIAL AND EMOTIONAL WELLBEING

Mental health

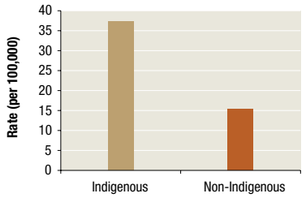
Indigenous males in all age groups experience high or very high levels of psychological distress and, in 2004-2006, were more than twice as likely to be hospitalised for mental and behavioural disorders than non-Indigenous males (AIHW, 2008). The extensive WA Aboriginal child health survey found that more than one-quarter of Indigenous males aged four to 17 years were at high risk of clinically significant emotional and behavioural difficulties - a rate 1.7 times higher than for non-Indigenous males of this age [Zubrick et al, 2005a]. Indigenous males in 2004-2006 died as a result of mental and behavioural disorders at almost six times the rate of non-Indigenous males [ABS & AIHW, 2008].

The higher levels of psychological distress among Indigenous people have been related to factors such as illness or disability, deaths, unemployment, alcohol or drug use, crowded housing and trouble with the law [ABS, 2004]. The emotional and behavioural difficulties of children in WA were caused by low self-esteem, quality of parenting and family dysfunction [Zubrick et al, 2005b]. Stereotyped portrayals of Indigenous men as indolents, alcoholics and abusers, together with racist attitudes and discriminatory behaviour, may also compound high levels of psychological distress among Indigenous males.

Self-harm and suicide

Attempted suicide is more common among Indigenous women, but completed suicide more so among young Indigenous men. During 2006-2007, Indigenous males were hospitalised for non-fatal intentional self-harm at 2.9 times the rate of non-Indigenous males, but at a lower rate than Indigenous females (RR 0.86) [SCRGSP, 2009]. Between 2003-2007 there were higher rates of suicide among Indigenous than among non-Indigenous males (RRs between 1.5 and 3.3), especially in SA and NT (Figure 4) [SCRGSP, 2009]. The WA Aboriginal child health survey reported that 12% of Indigenous males aged 12-17 years had thought about ending their lives in the previous 12 months, and 4% had attempted to do so in this period [Zubrick et al, 2005b].

Figure 4: Male standardised death rates for intentional self-harm, by Indigenous status, Australia, 2003-2007

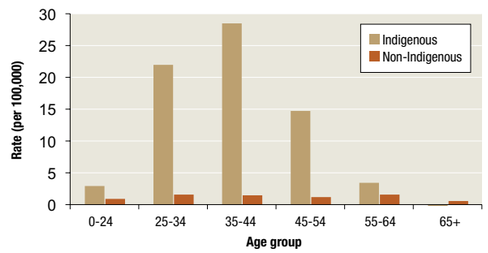


Family and community violence

In 2002, more than one-quarter of Indigenous males 15 years and over reported that they had been a victim of threatened or actual violence in the previous 12 months [ABS, 2004]. Indigenous males were hospitalised for assault at more than six times the rate of non-Indigenous males [ABS & AIHW, 2008]. Hospitalisation for assault from family violence was much more common for Indigenous females than males. Indigenous females were hospitalised because of family violence at 38 times the rate of non-Indigenous females and Indigenous males at 27 times the rate of their non-Indigenous counterparts [Al-Yaman et al, 2006].

Death rates from assault were 11 to 17 times higher for Indigenous males compared with non-Indigenous males aged 25 to 54 years (Figure 5) [ABS & AIHW, 2008]. Of the homicides involving Indigenous people during 2006-07, Indigenous males were the victims in 52% of the cases and the perpetrators in 65%. In more than 80% of all these homicides, neither the victim nor perpetrator was employed; in 78% of cases the perpetrators and victims were either intimate partners or family members and, in 32%, the motive was an alcohol-related argument (compared with 13% for non-Indigenous homicides) [SCRGSP, 2009].

Figure 5: Male death rates from assault, by Indigenous status and age group, Australia, 2001-2005



PART 2 - FACTORS THAT CONTRIBUTE AND FACTORS THAT PROTECT

The health conditions and causes of death just described are largely avoidable. Many of the factors that bring them about, and the factors that can protect against them, are amenable to human intervention and control. The question for this Report Card is how well the risks are being minimised and how well the protective factors are being promoted for Indigenous males.

FACTORS THAT CONTRIBUTE TO THE POOR HEALTH OF INDIGENOUS MALES

Loss of cultural role, country and language

The loss of purpose, cultural meaning and control that has resulted from cultural dispossession and family dislocation has played a profound role in the inordinate ill-health and premature deaths of Indigenous males.

The loss of role and cultural place experienced by Indigenous men diminishes their status, self esteem and sense of purpose, striking at the core of what it means to be a man. This psychosocial stress has profound implications for health, leading to high levels of substance use, self-harm and violence that become entrenched and reproduced in the next generation of young Indigenous males [Adams, 2003; Wenitong, 2002].

Use of Tobacco

More than half of Indigenous males smoked daily in 2004-2005 (51%) – more than twice the rate of non-Indigenous males. The highest incidence of daily smoking was in remote and very remote areas (58%). In WA, 31% of 12-17 year-old Indigenous males smoked regularly (56% of 17 year-olds) [Zubrick et al, 2005b]. One fifth of deaths and 12% of the burden of disease among Indigenous people have been attributed to tobacco use [Vos, 2007].

Use of alcohol

A greater proportion of Indigenous compared with non-Indigenous men do not regularly drink (17% and 11% respectively) [ABS, 2006]. The Indigenous men who do drink, however, drink at levels that put them at much higher risk of acute harms (RR 1.9) and risk of developing chronic conditions (RR 2.3) [Chikritzhs & Brady, 2007]. More than one-quarter (27%) of teenage males in WA (12-17 years) drank alcohol in 2004 [Zubrick et al, 2005b]. Hospitalisation for alcohol-related conditions in 2006-2007 was five times higher for Indigenous men than for non-Indigenous men [SCRGSP, 2009]. Alcohol-related deaths were also more common among Indigenous males. The influence of high-risk alcohol consumption on violent behavior far exceeds the influence of any other factor associated with violence in Indigenous communities [Snowball & Weatherburn, 2008].

Use of illicit drugs and volatile substances

Indigenous men used illicit drugs such as marijuana, amphetamines, ecstasy and designer drugs at rates two to three times higher than males in the general Australian population [AIHW, 2008]. Petrol sniffing is the most common volatile substance used in remote areas, with between two-thirds and three-quarters of Indigenous sniffers in central Australia being males [d'Abbs & Maclean, 2008]. The majority of Indigenous petrol sniffers are aged 12 to 19 years, with children as young as 5 years being witnessed sniffing petrol in the NT [SCSAC, 2004]. Petrol sniffing can result in chronic cognitive impairment and brain damage, as well as cause significant disruption to community functioning and draining of resources.

Poor nutrition, physical inactivity and excess weight

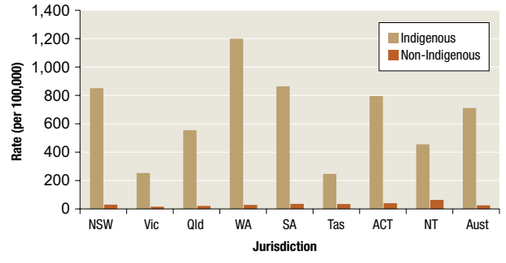
The limited available data suggest that a smaller percentage of Indigenous males eat a healthy diet than non-Indigenous males [ABS, 2006]. Almost one-quarter (23%) of Indigenous people surveyed in 2004-2005 had also run out of food at some point in the previous 12 months, and this was more likely in remote areas [ABS, 2006]. The higher cost of healthy foods in remote communities is a significant factor in diet [Brimblecombe & O'Dea, 2009].

About one-half of Indigenous males 18 years or older surveyed in 2004-2005 reported that they had not done any physical activity in the previous two weeks and, in all age groups, the rate of inactivity was higher than for non-Indigenous males [Penm 2008]. Among Indigenous people 15 years or older, 57% were obese or overweight – a rate 1.2 times that of non-Indigenous males [ABS, 2006]

Imprisonment and juvenile detention

Imprisonment can compound, rather than redress, health and behavioural problems, particularly substance use and violence. The rate of imprisonment of Indigenous males is 17 times that of non-Indigenous males. Disturbingly, Indigenous males aged 10-17 years are 28 times more likely to be in juvenile detention than non-Indigenous males (Figure 6), and almost 10 times more likely than Indigenous females [SCRGSP 2009]. In WA in 2006-2007, 22% of Indigenous offenders who were convicted received a custodial sentence, compared with only 9% of non-Indigenous offenders [AIC, 2009]. There may be fewer opportunities for diversion programs in rural and remote areas where Indigenous offenders can be living than in urban centres.

Figure 6: Detention of male juveniles, by Indigenous status and jurisdiction, Australia, 2007



FACTORS THAT PROMOTE AND SUSTAIN GOOD HEALTH AND LONG LIFE

Research and experience show that certain things can be protective when it comes to Indigenous people's health. How well are these determinants being promoted and maximised?

Access to culturally appropriate health services

Ready access to high-quality health and medical care is crucial to good health, particularly primary care, which can help address health problems early. Health services that are sensitive to Indigenous male cultural norms will result in better access from Indigenous men [Adams et al, 2003; Wenitong, 2002].

Currently, Indigenous males do not have ready access to health care, especially primary health care, either because the services are not there or because they are not used for cultural reasons. Aboriginal community-controlled health and medical services provide culturally appropriate care, but they are limited in number, and are not always geographically accessible [SCRGSP, 2009].

There is high usage of hospitals by Indigenous people, but the high rates at which Indigenous people discharge themselves against medical advice pose questions about how well hospitals address cultural needs [AHMAC, 2008]. Hospitalisation also reflects a reliance on acute clinical care at the expense of early prevention and a holistic approach to maintaining wellbeing [Brown & Blashki, 2005].

Control and self-determination

Research relating to Canada concludes that higher levels of community control of services in Indigenous communities, including health, education, and policing, and the presence of active efforts to secure land-rights, have a health protective effect, especially in reducing the risk of youth suicide [Chandler & Lalonde 2008]. This protective effect is a reflection of strong Indigenous identities and the centrality of culture and connectedness in Indigenous people's lives. There is also evidence of positive outcomes when men in Australian Indigenous communities act collaboratively to take responsibility for their behaviour and health.

There are examples of community control, and self-determination and empowerment among Indigenous men, and some of these are noted in the 'Good News and Best Practice' insert to this Report Card. However, there is limited capacity for Indigenous men to "define, understand, prioritise and control the determinants that affect their health and wellbeing" [National Framework, 2004]. Partnership and respect are central to achieving enduring health outcomes for Indigenous men.

Strong families, skilled parenting and positive male role models

Properly functioning families and skilled parenting promote the health, development and wellbeing of children and adolescents. Positive male role models also provide a stabilising and aspirational influence on teenage males and younger men.

Regrettably, violence is an occurrence in many Indigenous families. Child abuse and neglect are also prevalent [AMA, 2008]. Given the rates of serious illness and early death among Indigenous men, there are often limited older role models in families whom Indigenous boys and young men can emulate. For each non-Indigenous male under 15, there are nearly three non-Indigenous men over 30. For each Indigenous boy or adolescent under 15 there is fewer than one Indigenous man over 30 [ABS, 2008b].

Early identification and intervention

Early identification is important in preventing avoidable illness and premature death. This is particularly the case with violent and self-destructive behaviour, emergent criminality and youths who become marginalised and disconnected from community supports such as schooling and family. Effective interventions and supports are needed when risks are identified. However, many of the Indigenous communities that most need early intervention services and assistance may not have the capacity, resources and coordination to establish and maintain them

Education, employment and economic engagement

It is well known that there are significant correlations between good health, and educational attainment, secure employment and economic prosperity. To a significant degree, Indigenous people do not enjoy these conditions. Indigenous males are more likely not to attend school or to leave school between Years 9 and 12 [SCRGSP, 2009]. They are employed less, and their most common occupation in 2006 was 'labourer and related worker' [ABS, 2007]. The median gross individual weekly income for Indigenous males in 2006 was $277, compared with $627 for non-Indigenous males.

Self employment and successful business and entrepreneurial ventures are effective ways of benefiting from the Australian economy. Non-Indigenous Australians readily engage in such ventures and are supported by governments in many ways in doing so. But there are substantial cultural, geographical and financial barriers to Indigenous Australians doing the same. Many of these barriers reflect inequities in infrastructure and services that are readily provided to, and taken for granted by, others as a matter of right. Sustaining one's cultural identity should not be incompatible with equitable access to the fundamental resources necessary to enjoying the benefits of the Australian economy, with the empowerment and health advantages that this brings. Part of this empowerment must be to foster a greater representation of Indigenous people among the professions (doctors, nurses, teachers, dentists, psychologists, lawyers, engineers, etc.)

KEY FINDINGS

Significant rates of preventable illness and avoidable death continue to be experienced by Indigenous males. National efforts to close that gap will only succeed if the health needs of Indigenous males – boys, adolescents and men - are appropriately addressed.

While Indigenous men die early, much of the Indigenous male population is still young, and this gives promise for healthier outcomes for the next generation of men, if the right support and opportunities are provided and capacities built. Addressing the health of Indigenous males must be seen in a generational context.

The loss of status, self-esteem and sense of purpose experienced by many Indigenous men is intimately bound up with the health of Indigenous males. Directions forward lie in Indigenous men recapturing control of their lives and the factors that determine their health and life prospects.

Genuine partnerships between Indigenous men and their communities, and Australian governments and agencies which make key decisions about health resourcing, are crucial to achieving positive and enduring health outcomes for Indigenous males.

The high level of preventable conditions and premature death among Indigenous males is clear indication that they do not have sufficient access to high quality comprehensive primary health care services, or access to sufficient numbers of culturally competent doctors and health professionals who are attuned to the cultural and other factors that contribute to successful outcomes for Indigenous males.

The rate at which Indigenous men are imprisoned, and boys and adolescents placed in juvenile detention, is intolerable and must be addressed. We cannot allow future generations of Indigenous men to transition to adulthood inside correctional facilities.

The suicidal, self-destructive and violent behaviours of some Indigenous males is an area of great concern, along with the alcohol use and psychosocial stresses that contribute to these behaviours.

There are substantial cultural, geographical, educational, financial and infrastructural barriers to Indigenous people engaging in successful business and entrepreneurial ventures and pursuing careers in the professions. Successful engagement in the Australian economy can bring health advantages and empowerment to Indigenous people.

The expertise and assistance of Professor Neil Thomson and the Australian Indigenous Health*InfoNet* team has been greatly appreciated.

The AMA recognises the significant commitment that Australian governments have recently made through the Council of Australian Governments to close the Indigenous health gap, particularly in relation to maternal and family services and chronic disease management.

The AMA believes that this commitment can be strengthened through development of a national plan to close the gap which includes a strategy for the health of Indigenous males that provides for a continuum of care across their lifespan. This strategy should incorporate, or be supported by, the following measures:

Primary health care services and workforce

To begin to address the inadequate access of Indigenous people, including males, to appropriate primary health care, the AMA calls for:

- **a five-year Capacity Building Plan for Aboriginal and Torres Strait Islander peoples, with additional grants of $440 million a year over five years to Indigenous primary care services (with $500 million a year sustained thereafter) for enhanced infrastructure and services to close the health gap for Indigenous people and to allow Aboriginal Medical Services to:**
  - **offer mentoring and training opportunities in Indigenous health in Indigenous communities to Indigenous and non-Indigenous medical students and vocational trainees,**
  - **offer mentoring and training opportunities to Indigenous and non-Indigenous students in nursing, dentistry, allied health and psychology, and to trainee Aboriginal health workers.**
  - **offer mentoring and training for Indigenous men to become health workers, and**
  - **offer salary and conditions for doctors wishing to work in Aboriginal Medical Services that are comparable to those of State salaried doctors and**
- **new funding of $16.5 million per annum over six years for the development of Indigenous specific medical training to deliver 430 medical practitioners to work in Aboriginal health settings and**
- **provision in all jurisdictions of a guaranteed postgraduate place for each Indigenous medical graduate, to tackle the serious under-representation of Indigenous people in all areas and specialties within the medical workforce.**

Quality care in all Australian health services

Indigenous people will not always have the opportunity to, or want to, attend an Aboriginal health or medical service. It is important that all Australian health and medical services operate in a way that makes them as accessible and of as high quality as possible for Indigenous people, particularly males. The AMA believes that this quality and accessibility can and should be improved through:

- **developing and delivering training modules, resource material and ongoing advice for all Australian medical practices on Indigenous health issues, Indigenous-specific health initiatives and culturally appropriate service delivery. This funding should be provided to Indigenous health organisations or accredited trainers for these purposes,**
- **strong government incentives to encourage doctors and medical practices to undertake this training and skill enhancement and**
- **systematic improvements in cultural safety and awareness in public hospital services.**

Local community capacity-building

Health responses should reflect the diversity of the Indigenous male population. There should be as much opportunity as possible for local solutions to local problems. There are many examples of successful community-based health programs developed and operated by and for Indigenous communities. The AMA believes that this capacity should be extended through:

- **allocating $10 million per annum over 10 years in new funding for grants to community groups or NGOs for health-related capacity building in Indigenous communities. A proportion of this funding should be quarantined for the development of:**
  - **local community-based preventive programs to address the health and behaviour of Indigenous men, particularly self-harming and violent behaviour. These programs should capitalise on the fact that there are many men in Indigenous communities who are committed to, and capable of, improving the health of their fellow men. Of particular importance are community men's groups, and**
  - **establishing community-based mechanisms for early identification of Indigenous males at risk (including boys and teenagers at risk of marginalisation and problematic behaviour) and intervention pathways and options for support.**

Health promotion and chronic disease prevention

A much greater effort is needed to address the risk factors for preventable cardiovascular conditions. The AMA calls on COAG to establish a national health promotion strategy for Indigenous peoples that:

- **is targeted as appropriate to the specific needs and characteristics of males and females,**
- **provides culturally appropriate information and education on chronic disease risks and practical and appropriate measures and strategies that Indigenous families can adopt to address them and**
- **increases the opportunities for Indigenous people to make healthier choices the easier ones, including making nutritious foods more readily available and much more affordable in rural and remote areas.**

To support this strategy, governments and local communities should explore opportunities and best-practice measures to reduce the availability and demand for alcohol in Indigenous communities where abuse is a problem.

Indigenous males in prison and juvenile justice system

Every effort must be made nationally to keep Indigenous people out of prison and detention, particularly boys, adolescents and older teenagers. This can be achieved through:

- **local community-based diversion programs for (predominantly male) Indigenous offenders, directing them away from the justice system and incarceration.**

It is crucial that Indigenous people who are in prison have access to high quality and culturally appropriate health care and post-release support. The AMA calls for:

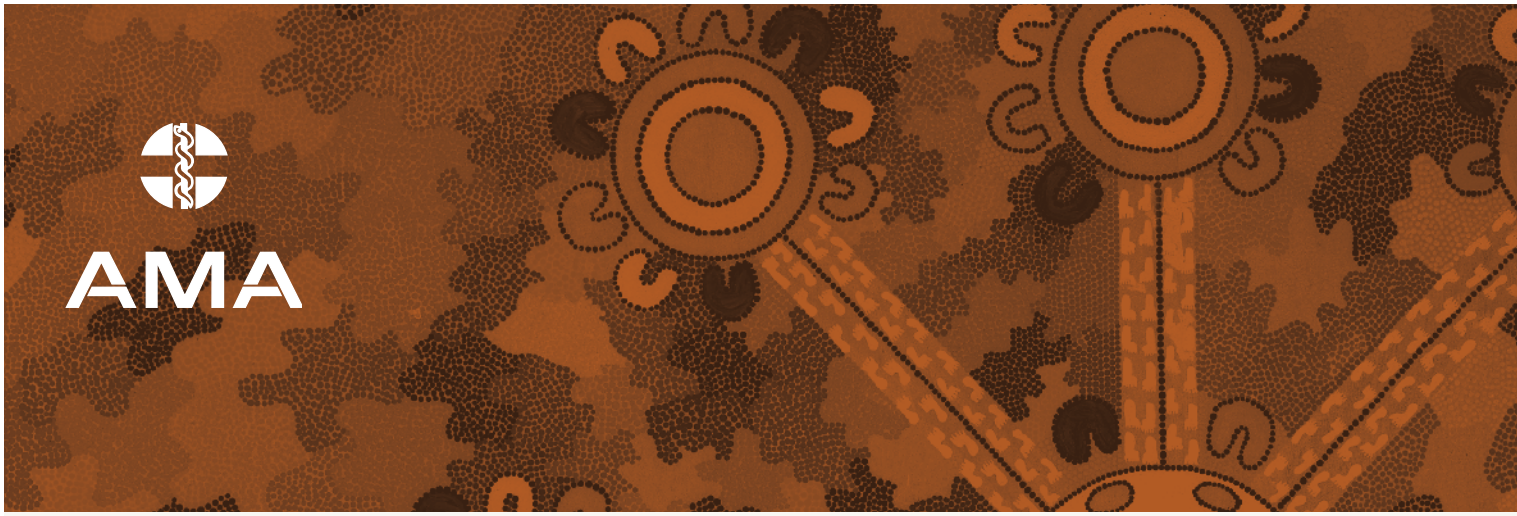
- **culturally appropriate medical services and health programs in all prisons and detention facilities with Indigenous populations. The focus of these health programs should be social and emotional wellbeing, substance use, problematic behaviour and targeted prevention (eg, blood-borne virus transmission) and**
- **a national scheme of post-release support for Indigenous prisoners to address substance use and the potential to re-offend.**

Social and emotional wellbeing

The AMA reiterates its 2008 recommendation that culturally appropriate services addressing mental health and social and emotional wellbeing should be established within two to five years in urban, regional and remote locations. A particular focus should be psychosocial stressors for Indigenous males, self-harming behaviour and family violence. Those services should seek to facilitate the protective potential that lies in strong Indigenous identity, and the centrality of culture and connectedness in Indigenous people's lives.

Economic engagement

The AMA believes that much more needs to be done nationally to improve the access of Indigenous people to the benefits of the Australian economy, in terms of greater capacity and opportunities for employment in the full range of occupations, and of self-employment and opportunities for successful business and entrepreneurial ventures. Improvements in school retention and access to higher education for Indigenous people are central to this. Governments also have at their disposal many fiscal and regulatory levers that can be applied to improve business and entrepreneurial opportunities.



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