A literature review for Indigenous men's groups

Janya McCalman, Komla Tsey, Mark Wenitong, Mary Whiteside, Melissa Haswell, Yvonne Cadet James, Andrew Wilson

February 2006

School of Indigenous Australian Studies and School of Public Health and Tropical Medicine, James Cook University

Acknowledgments
This literature review was written to inform our research with north Queensland Indigenous men's groups. We have been using a participatory action research process with the Yaba Bimbie Men's Group at Yarrabah since 2001, and with the Ma'ddaimba Balas Men's Group at Innisfail since 2004. We would like to thank members of Yaba Bimbie, particularly David Patterson, Bradley Baird, Les Baird and Dennis Warta; and members of the Ma'ddaimba Balas, particularly Darryl Ahkee, Anthony Jia and David Ambrum, for sharing their reflections and analyses of the issues facing Indigenous men and strategies to address them.

Indigenous men's groups : a literature review.

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ISBN 0 86443 756 10.

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School of Indigenous Australian Studies and School of Public Health and Tropical Medicine,
James Cook University
McGregor Rd
Smithfield
QLD 4878
Ph 4042 1046
janya.mccalman@jcu.edu.au

Contents

Summary

What this document is about
The vision of Indigenous men has been to take greater responsibility themselves to improve the status of men's health and play their rightful role as leaders, fathers, uncles, husbands and grandfathers. They have adopted a diverse range of strategies, including the development of community-based men's groups.

Although there is considerable diversity in the composition and priorities of Indigenous Men's Groups, they have a common aim of empowering men, supporting and being a role model for younger Indigenous men, and addressing the factors identified as contributing to social dissatisfaction and poor health and wellbeing in Indigenous communities. The scope of men's groups is often very broad and holistic and they face a huge range of expectations, issues and challenges. Their resource base is generally very limited. It can be extremely challenging for men's groups to know where to start, or how to direct their energies for maximum impact.

This literature review is intended to provide a guide for men's group leaders (and those who support them). It provides a brief overview of the available best practice evidence for a range of strategic initiatives which Indigenous men may consider to be important. It indicates possible directions and related issues which may help men's groups clarify or prioritise their vision, assist with planning and implementing strategies, or provide evidence as a basis for advocacy to other organisations.

How reliable are the sources of information used
The review is based on relevant Australian and international literature. It was conducted by searching multiple databases of the Austhealth library for relevant publications listed between 2001-2005. The breadth of this literature review has meant that both the theoretical frameworks and specific program or issue areas have been canvassed only to the extent of extracting key learnings. Hence, it is recommended that men's groups that wish to focus on any specific area should conduct their own targeted literature search.

What our review found

The worst health status in Australia
Current mortality and morbidity data suggest that the health of the Aboriginal and Torres Strait Islander male population is the worst of any population in Australia on every health indicator; life expectancy, infant mortality, child mortality and childhood and adult morbidity. Indigenous males' life expectancy is 59 years (18 years less than the Australian average). Indigenous men die at three times the rates of other Australian males from all causes and at all life stages, and were twice as likely to be hospitalised than non-Indigenous males in 2000-01.

Within the Indigenous population, men are faring worse than women as the life expectancy of Indigenous women is 65 years (17 years less than the Australian average) and age-specific death rates for men are higher in every age group.

Indigenous men have been displaced and are still subjected to abuse, marginalisation and racism. Structural issues such as educational and employment opportunities determine men's ability to be sober and well, and many men do not have the confidence, opportunity or facilities available to help them improve their health status or position within their family or community. Men are the main perpetrators of violence against women and children, die earlier from chronic diseases than women, have higher rates of suicide and higher imprisonment rates. "*Something has gone seriously wrong and there is an urgent need to address issues related to Indigenous men's health*" (Aboriginal and Torres Strait Islander Women's Task Force on Violence 2000).

Approach and scope of men's group activities

Indigenous men's groups aim towards the holistic Indigenous view of health, defined as "*not just the physical wellbeing of the individual but the social, emotional and cultural wellbeing of the whole community. This is the whole-of-life view and it also includes the cyclical concept of life-death-life*" (National Aboriginal Health Strategy Working Party 1989). In line with this holistic perspective, the national framework for improving the health and wellbeing of Aboriginal and Torres Strait Islander males (2003) also argued that a broad approach, including addressing the social determinants of health is necessary.

Indigenous men's groups emphasise the need for men to have culturally safe space for healing, reflection and re-establishment of their roles in the family and community. They often emphasise that the group should be owned and managed by the men themselves. Men's group initiatives impact not only on men, but also on family and community members.

Within their (significant) resource limitations, Indigenous men's groups tend to adopt multi-strategic programs that can encompass advocacy for changes to the broader social determinants, community development, developing personal capacity and improving the orientation of health services. Strategies have included increasing employment opportunities, supporting men through the courts, providing anger management, family wellbeing, family violence or other programs, organising sporting or recreation programs, providing traditional cultural programs/activities, developing a "Men's Place", working with young people, and improving men's access to health services. The health promotion literature provides evidence that this multi-strategic approach is likely to be more effective that single strategy initiatives, although men's groups need to be realistic about what is possible with limited resources.

Relevant theoretical and conceptual frameworks
Within Western theoretical paradigms, Indigenous men's group strategies can fit the frameworks of primary health care, health promotion, and/or empowerment. Self determination and empowerment are seen as central to raising self-esteem, quality of life, health status and spiritual well being and some men's groups have implemented explicit empowerment programs.

Indigenous men's groups have minimal involvement with the mainstream men's movement, but there are some synchronicities. The aim of the mainstream men's movement is to incrementally detach small numbers of men at a time from the defense of patriarchy, through a variety of struggles in diverse sites employing alliance politics or overlapping interests or commitments between different groups. However, the literature provides evidence that there is currently little explicit anti-sexist work being done in men's groups; the few notable exceptions are to be found in the fields of anti-male violence and youth work. Members of therapeutic men's groups may not recognize their use and abuse of gender-based power in relationships, and end up seeing themselves as victims instead of examining their values and attitudes.

The situation for Indigenous men is more complex. While they experience gender-related power and authority within their families and communities, there is significant racial discrimination and disadvantage within the wider Australian society. Men's groups may encourage and support men to adopt non-traditional roles (such as active involvement in parenting, housework etc). But men's lack of access to social, education and economic advancement as measures of masculine success (in a dominant white culture) can also result in negative responses to gender politics and assertion of power in one of the few spheres available to them – violence towards women and children.

Resources
The one factor, above all others, that remains a hindrance to the establishment and continuance of Indigenous men's groups, is that of inequitable funding opportunities. There is no dedicated men's health funding, and Indigenous men's groups are constantly frustrated at the process of locating and applying for limited one-off project-based funding. The stereotypical image of an Indigenous man is often that of a disempowered passive welfare recipient, and commonly a problem drinker and wife basher. However in the absence of funding support, some Indigenous men have been demonstrating a huge voluntary commitment to improving the status of men's health, and playing their rightful roles as leaders, fathers, uncles, husbands and grandfathers.

The range of program interventions available
The literature describes a broad range of program interventions which may be considered by Indigenous men's groups in developing priorities or strategic plans for their work. They include:

- **Personal development or leadership programs** that provide opportunities for participants to build trusting relationships, think about their individual needs and aspirations, and develop life skills, strategies and support mechanisms to help each other meet those needs.

- **Parenting programs** to assist Indigenous adult males to face the enormous challenges and pressures in raising children, in particular the male children and youths who are their special responsibility: whether as fathers, grandfathers or uncles.

- **Youth programs** which work with teenage boys through "holding" where older generations assume the responsibility to care for and look after younger people and assist young boys/men develop a vision for the future.

- **Sports and fitness programs** are an important part of Aboriginal community development, contributing to both physical and emotional wellbeing. This is especially true for the health of young people.

- **Tradition and culture programs** that promote the return to country/culture, and educate younger men and men who have been removed from cultural contact about traditional systems, initiations and obligations of Aboriginality. Internationally, when Indigenous communities have undertaken programs for socio-cultural and spiritual recovery, significant economic recovery and reduced youth suicide have followed.

- **Establishing men's places** which can house a range of facilities and services including men's clinical services, places for discussions and education, "cooling off" places, group meetings, and recreation, training and work activities.

- **Alcohol and drug programs** including advocacy for multi-strategic programs to deal with the grog and drug problem as a priority. The aim of alcohol and drug programs can be either to minimize alcohol- or drug-related harm and/or to promote abstinence and zero tolerance of abusive behaviour. The literature describes the currently established cultures of Aboriginal drinking as leading to abuse because many men drink to get drunk.

- **Improving men's access to health services, care and treatment**, including advocating for the employment and retention of Indigenous male health workers, development of partnerships between Aboriginal health workers and mainstream health services, and advocacy for improved health service provision.

- **Suicide prevention programs** which provide support for people who threaten suicide or face stressful situations, link young people with a

- **Crime prevention programs** including those which intervene early in the developmental pathways that lead to crime and substance abuse, advocate for controlling the consumption of alcohol; or advocate for alternative dispute resolution and community input into pre-court sentencing.

- **Correction of offending behaviour** through providing court-mandated and court-referred diversionary programs; advocacy for improved services to address and remedy the causes of offending behaviour and successfully reintegrate offenders into the community after prison release.

- **Family violence prevention and early intervention programs** through projects aimed at intergenerational issues such as father-son relationships and mentoring of Aboriginal youth by Elder figures; the creation of men's "cooling off" places; establishing domestic and family violence outreach services targeted at men; organizing men's healing camps and/or healing journeys; and formulating local violence prevention strategies aimed at indigenous youth. There are also interventions that address the broader issues of grief and loss, health, housing, education and employment.

- **Family violence perpetrator programs** including programs which target men who have been convicted of committing offences of violence (some try to change male/community attitudes towards violence and others focus specifically on individuals); and advocacy for controls over perpetrators to prevent future violence.

- **Employment programs** through increasing access to the enjoyment of traditional subsistence resources, encouraging and supporting men to apply for existing employment opportunities in mainstream organisations, encouraging men to develop businesses, and advocacy to change the nature of welfare programs and develop community economies.

- **Developing or advocating for social enterprises** (sustainable business enterprises which have a social purpose) to address upstream health issues as well as having flow-on employment and economic impacts for the community.

- **Advocacy to influence the broader community and societal issues** since men's groups do not have the power or resources to try to influence the multiplicity of social determinants of Indigenous men's health alone, they can advocate to influence government or community-level policies which affect them. The literature emphasises the importance of Indigenous self-determination in developing and implementing programs

Reflections on the review

Despite efforts to improve the Australian situation over the last 30 years, evidence suggests that the poor health status of Indigenous men has persisted and that there is deterioration in many aspects of Indigenous health and wellbeing. Indigenous community leaders have called for more innovative and empowering interventions that enhance people's capacity to take greater control and responsibility for their situation, including the development of Indigenous men's groups.

While both the health promotion literature and broad indigenous understandings of health support men's groups complex multi-level approaches, this also creates challenges about 'where to start' without feeling overwhelmed. The evaluation of such complex interventions and demonstration of outcomes from (often long-term) strategies is also difficult and resource-intensive. As a result, there has been little recognition of the contribution and potential roles of Indigenous men's groups in providing a grass roots response to a broad range of issues, and consequently they have been under-resourced.

The challenge for men's groups is to strike a balance between the need to intervene at multiple levels versus the need to prioritse and demonstrate outcomes. We hope that this literature review will provide some support for the work of Indigenous men's groups to encourage a more strategic approach to addressing their priority issues, and consequently to increase their effectiveness and credibility. We hope that it will also assist government organisations to recognise and support/resource the work of Indigenous men's groups.

Section 1: Background

How this literature review is structured

Section one provides a background to the literature review including it's aim, methodology, and limitations.

Section two provides a context for the work of Indigenous men's groups, describing the health status of Indigenous men, the frameworks and principles which they have developed to address their health and role in the community, and the growth of Indigenous men's groups.

Section three addresses key underlying theoretical frameworks that influence or underpin the work of Indigenous men's groups. From the public health field, these concepts include health inequalities and empowerment, health promotion, primary health care and the closely related concepts of community development and community capacity building, and resilience. From the mainstream men's movement, theories of masculinity, the history of the mainstream men's movement and the development and rationale for mainstream men's groups are described.

Section four describes a range of evidence-based program interventions which Indigenous men's groups might consider in developing priorities or strategic plans for their work. The review does not intend to imply that addressing these issues could or should be solely or even primarily the responsibility of men's groups. Men's groups may choose either to directly implement strategies or to advocate for change within these broad areas. The strategies include:

Programs to work with individual men and their families

- Counselling, leadership and personal development programs
- Parenting programs
- Work with young men and boys
- Sport and recreation programs
- Culture and tradition and spiritual recovery programs
- Suicide prevention programs
- Alcohol-related programs
- Improve access to health services
- Work with the criminal justice system
- Family violence programs
- Employment strategies
- Social enterprise initiatives
- Advocacy to influence the broader community and societal issues.

Finally, the conclusion of the literature review can be found on page 49 and references are provided from page 53.

Aim of the literature review

Since 2001, James Cook University (JCU) has been working with the Yaba Bimbie Men's Group at Yarrabah using a participatory action research process. The research aims to engage and support the members of the group to, in their own words 'take their rightful place in society'. In 2004, this research process was extended to the Ma'ddaimba Balas Men's Group at Innisfail. Micro-evaluations of Indigenous men's groups in communities including Yarrabah and Innisfail have found that men's groups have a broad vision which aims at long-term social and cultural change, and that Indigenous community members are generally very supportive of their work. Given the impact of colonisation on Indigenous men and consequent loss of self esteem and self respect, loss of culture and country and spiritual wellbeing, Indigenous community men and women feel that it is critical that men determine their own agendas and take action to redress their situation.

Within the broad social, political and economic context of Indigenous men's health, however, there are few resources to guide Indigenous men in developing effective interventions at community level. This literature review has been undertaken to critically examine relevant current theoretical frameworks which might inform the work of men's groups and provides some evidence about the effectiveness and limitations of relevant programs.

Methodology and limitations

This literature review built on an earlier preliminary canvassing of the literature in 2001 which reviewed what had been written about men's groups (unpublished report, University of Queensland 2001). Since the original review, this team of researchers has worked closely with two Indigenous men's groups. We have observed a significant breadth and diversity of interests, issues and processes and have published our findings in several peer reviewed journals (Tsey et al 2002, 2004, 2004a).

In response to issues that have arisen through our on-the-ground experience, we decided to revisit the literature and follow the threads that are of concern to Indigenous men in these settings. This review was conducted by searching multiple databases of the Austhealth library. These included the Australasian Medical Index, Australian Public Affairs Information Service (APAIS), Aboriginal and Torres Strait Islander Health Bibliography, Health Issues in Criminal Justice (CINCH-Health), Drug database, Health and Society database, Blackwell Synergy, and Rural and Remote Health database for relevant publications listed between 2001-2005.

Due to the broad nature of Indigenous Men's Groups, several search strategies were engaged. These included searching a combination of words "Aborigin*" and "Indigenous" with "male", "men", "young men", "men* group*", "men health",

“family violence”, “crime”, “access health services”, “men advocacy”, “men alcohol”, and “social determinant*”. As the search strategy indicates, where possible, the literature canvassed pertained to Indigenous Australians, but in some areas, there was little evidence of program effectiveness, so more generic literature was sourced. The literature was reviewed and 175 citations were entered into Endnote, of which 121 references are provided in this report.

The breadth of this literature review (which reflects the breadth of men’s group interventions) has meant that both the theoretical frameworks and specific program or issue areas have been canvassed only to the extent of extracting key learnings. It is likely that critical evidence within these areas may have been overlooked. Hence, it is recommended that men’s groups that wish to focus on any specific area should conduct their own targeted literature search.

Section 2: Indigenous men's health and Indigenous frameworks

Indigenous Men's Health

Before colonisation, Australian Indigenous men had meaningful, active roles with authority and status within the family and community (Adams 2001). The kinship system ensured that members of a community had clearly defined responsibilities and obligations. Male elders were responsible for the management and maintenance of traditional obligations, sacred objects, spiritual matters and the performance of rituals. They provided leadership, educated the young, advised on marriage partners and were custodians of the law. Young men had a clear passage to manhood. During initiation processes, boys were taught the rights and obligations of adult males and some of the secrets of the sacred law. Initiation was a test of worthiness and courage, designed to instill qualities of discipline, self-reliance, obedience and cooperation (Jacob 1991 cited in Australian Indigenous Health InfoNet, 2005).

The impact of colonisation resulted in enormous loss, trauma and grief including loss of land; loss of traditional ways; loss of roles as hunter/providers /warrior/teacher of young men; loss of health; lack of recognition of human status (by Terra Nullius) and loss of freedom. Culture was undermined; control over their lives was lost; and children were removed (Indigenous Youth and Men's Health Conference, 1997). The consequence has been a devastating loss of self esteem and self respect, loss of culture and country and spiritual wellbeing (Briscoe 1999, Spry 1999).

While Indigenous men and women share the burden of pain, it is the pain of Aboriginal and Islander men which is most likely to go unrecognized. The roles of Aboriginal men, in particular, have been devalued and loss and pain is transmuted into frustration and anger (Hunter 1998). These and other issues such as unemployment and racism make Indigenous males more vulnerable to mental illnesses (Hunter 1993). It can also result in acting out (such as child neglect, sexual abuse, emotional abuse and physical abuse) or self-medicating with alcohol or other substances (Swann and Raphael 1995).

Indigenous people now comprise 2.1% of the Australian population, with approximately 230,000 being male (Australian Indigenous Health InfoNet 2005, Australian Bureau of Statistics 2002). Indigenous males' life expectancy is 59 years (18 years less than the Australian average). This compares with a life expectancy of 65 years for Indigenous women, almost 17 years less than the Australian average (SCRGSP 2005). The death rate of young and middle aged Indigenous males is of particular concern, with devastating consequences for their culture, families and the community.

The health status of Indigenous Australians is significantly worse than that of the non-Indigenous population on every health indicator; life expectancy, maternal

mortality, infant mortality, child mortality and childhood and adult morbidity (AIHW 1998, NHMRC 1997). Current mortality and morbidity data suggest that male's have the worst health of any population in Australia (Wenitong 2002).

Indigenous health has not improved to the extent of that of other Indigenous populations who have suffered similar colonisation and loss of traditional ways. Hence, from 1985-96, the mortality rates fell about 9% for Aboriginal and Torres Strait Islander people in Australia, compared to a decline of 44% for New Zealand Maori people, and 30% for United States American Indians. There have been significant changes in the age groups where deaths are occurring and contribution of conditions, with a sharp decline in the death rates from infectious diseases, and large increases in mortality from chronic diseases (Working Party of Aboriginal and Torres Strait Islander Male Health & Well Being Reference Committee (WPATSIMHWBRC) 2003)

Indigenous men die at three times the rates of other Australian males from all causes and at all life stages. Within the Indigenous population, men are faring worse than women as age-specific death rates for men are higher in every age group. Between the ages of 15 and 24, the rates are four times higher. Most Indigenous men die from cardiovascular disease (28% deaths), injuries (16%), respiratory disease (9%), cancer (8%) and endocrine diseases including diabetes (9%) (WPATSIMHWBRC 2003).

Indigenous males were twice as likely to be hospitalised than non-Indigenous males in 2000-01. The main reasons were for kidney dialysis (28%), injury and poisoning (12%), respiratory disease (11%), digestive diseases (7%) and mental and behavioural disorders (6%) (Australian Indigenous Health InfoNet 2005). Health risks factors include low socioeconomic status; poor living conditions; poor nutrition; the highest rate of tobacco use across all age groups of the Australian population; the harmful use of substances; and violence (WPATSIMHWBRC 2003).

The main reasons for health differentials include lifestyle risk factors, physical environmental factors and health service access and utilisation. Broader social determinants of health include socioeconomic status, race and ethnicity, gender, sociocultural and psychosocial factors. Those who occupy the lower levels of the socioeconomic hierarchy (measured by income, education or occupation) fare significantly worse in terms of their health. Perceived discrimination and race-related stress are also health-damaging factors (Dixon and Welch 2000). The Human Rights and Equal Opportunity Commission predicts that in Australia, the level of inequality is likely to worsen substantially over the next decade due to the faster growth rate of the Indigenous population (HREOC 2004).

Most Aboriginal and Torres Strait Islander males do not drink alcohol (only 42% Indigenous people reported drinking compared to 62% of the general population in the week before the 2003 national AIHW survey). However those who drink

tend to do so at harmful or hazardous levels (Australian Bureau of Statistics, 1999). Alcohol plays a significant role in injury cases (such as road crashes) and the effects of alcohol misuse are key risk factors in suicide, child abuse, self-harm and violence on others. Excessive alcohol consumption also has a strong relationship with emotional and social wellbeing (WPATSIMHWBRC 2003).

At 54%, the level of smoking among the Aboriginal and Torres Strait Islander population is twice as high as that in the overall Australian population. In some communities, the level has been reported to be as high as 80% (WPATSIMHWBRC 2003). Half of those responding to the national AIHW survey said they had used cannabis compared to a third of other Australians, and petrol sniffing is a significant problem for young males, particularly in remote communities.

On a wide range of social and economic indicators, Indigenous men also fare poorly compared to their non-Indigenous counterparts. Indigenous males have lower educational achievements than both non-Indigenous males and Indigenous females. In the 2001 Census, 16% Indigenous males completed year 12 compared with 19% Indigenous females. Approximately 19% of Indigenous males reported a non-school qualification compared with 46% of non-Indigenous males (Australian Indigenous Health InfoNet 2005).

In 2001, only 27% of Indigenous males over 15 years were employed in non-Community Development Employment Projects (CDEP) or 'work for the dole' jobs, 20% in CDEP jobs (which often involve very basic and non-productive work) and 22% were unemployed (ABS 2003). In 2001, the Indigenous average gross household income was $364 per week, 38% less than the average of $585 for the total population (ABS 2003). Just over 80% of adults depend on some form of government support to prop up their presence in the labour force or sustain them outside of it (Hunter and Gray 2001).

Indigenous men are the main perpetrators of violence against Indigenous women and children, have higher rates of suicide and higher imprisonment rates. Aboriginal and Torres Strait Islander people are over-represented among both victims of crime and offenders (Fitzgerald and Weatherburn 2002) and at increasing rates (ABS 2001, ABS 2003a). Contact with the criminal justice system starts early and there is a continuing high level of contact, especially for young males (Mackay 1996). The longer-term consequences include the likelihood of adult incarceration. Indigenous people are incarcerated at 15 times the rate for the non-Indigenous population and represent 20% of the prison population but only 2.1% of the Australian population (ABS 2003a in Australian Indigenous Health InfoNet 16). There is little national data available about the health of Indigenous prison inmates (Wenitong 2002).

Indigenous men are not homogeneous and some groups need to be specifically considered in the provision of health services. The health needs and profiles of

remote, rural and urban men can be slightly different. Traditional men in remote areas may require more strict gender-specific health services (men's business), and in urban areas, issues such as illicit substance misuse can be more prevalent. Indigenous gay and transgender males also have unique needs. Anecdotal evidence suggests that there are significant numbers of men who have sex with men in some specific communities and male adult to youth rape also occurs in some communities, with its associated sequelae (Wenitong 2002).

While this literature review addresses a gendered approach to health service provision, Adams points out the interdependence of family and community members "*If the man is unwell he cannot provide for his family, therefore, the family suffers. If the family suffers then they draw on resources from the community. The overuse or dependence of the community causes it to dysfunction.…If the man is well and the family is satisfied then the community stays healthy and all will function to their fullest potential"* (WPATSIMHWBRC 2003).

Indigenous frameworks and principles

The vision of Indigenous men has been to take greater responsibility themselves to improve the status of men's health and play their rightful role as leaders, fathers, uncles, husbands and grandfathers. They see the empowerment of Indigenous males as crucial to the raising of self-esteem, quality of life, health status and spiritual wellbeing. They have advocated for a redirection of resources to enable culturally appropriate and accessible health services for men including greater recruitment and involvement of male health workers and nurses. They also recognise the need for holistic strategies to address the multiple factors that determine men's health such as employment, education, high incarceration rates and disempowerment of men (Briscoe 1999).

The National Aboriginal and Torres Strait Islander Male Health and Well-being Reference Committee (NATSIMHWRC) established a National Framework for Improving the Health and Well-being of Aboriginal and Torres Strait Islander males. The national framework argues for a broad approach addressing the social determinants of health. In general, the Working Party would like to see:

- All Aboriginal health forums consider prioritising male health issues within existing and future planning processes; and
- All national strategies consider their impact on Aboriginal and Torres Strait Islander male health (Adams 2003).

The framework is guided by the following core principles:

- Indigenous male health and social well-being must be determined by Indigenous males and their families/communities in line with local cultural traditions;

- Health should be improved by effective and sustainable strategies across the continuum of care, emphasising prevention and comprehensive primary health care;
- Access to mainstream and Indigenous-specific health services must be improved across all settings and take into account the particular needs of those influenced by physical and/or psychological impairment or sexual orientation;
- Culturally and gender appropriate services should be offered in a range of settings including correctional facilities and schools;
- Sustainable partnerships between Indigenous males, their families/ communities, government, non-government, community and private sector organisations should be encouraged;
- Indigenous males should be involved in planning, implementation and management of health initiatives; and
- Initiatives should be evidence-based or designed to produce evidence (Adams 2002).

While acknowledging the importance of multiple strategies, some writers believe that there should be a priority focus on single issues. Pearson (2001), for example, argues that the grog and drug problem must be dealt with as a priority. He states "*what our people need more urgently than an expansion of the health care system is an immediate dismantling of the passive welfare paradigm and an end to permissive thinking about grog and drug policy*" (Pearson 2001).

Commonwealth, States and Territories have responded to the national framework by developing policies and strategies for both Indigenous and mainstream male health. They have funded some Indigenous male health education, health promotion and screening programs, based on the principles of accessibility; affordability; accountability; acceptability; appropriateness; flexibility, and holistic approach. Initiatives include discrete men's clinics; men's programs within Aboriginal Health Services; men's business camps; sobriety groups; sports initiatives; parenting projects; and men's support groups**.** Few have been rigorously evaluated.

An evaluation of the delivery of services accessible to Indigenous Australian men found that attempts had been made to place men's health on national, state and local policy agendas. But the outcomes did not compare with those of women's health issues and did not necessarily encompass an Indigenous perspective (Adams 1998).

The growth of Indigenous men's groups

Indigenous men have been forming groups that aim to empower men, support and be a role model for younger Indigenous men, and ultimately address the underlying factors which contribute to social dissatisfaction and poor health and wellbeing in Indigenous communities. In the words of Butcheulla Badtjala men's

group spokesperson, Norman Barney, "….*The need for such a group is imperative for men to come together and address problems of our families, domestic and family violence issues, health, drugs and alcohol matters affecting our families, supporting our youth and our community*" (August 2004 – cited in Reilly, Dec 2004 p 7).

Men's groups emphasise the need for men to have culturally safe space for healing and to encourage and empower them to reassess, review and re-establish their roles in the family and in their community (Franks 2000). They often emphasise that the group should be owned and managed by the men themselves. Issues addressed include the impact of colonisation, spirituality, how to ensure identity, tradition and cultural heritage are taught for future generations and parenting. Anger management and violence issues, and associated alcohol and marijuana use are also often addressed (Franks 2000). Men's groups generally have a psycho-educational approach aiming toward behaviour change, rather than a primarily supportive or therapeutic approach. Sometimes, the group takes on a community welfare role, such as offering family support, counselling and support for men in prison. Groups may also provide a structure for men to start to explore some ways in which they can influence alcohol and drug issues and other social determinants such as employment, providing an opportunity for men to start to take some control of their lives.

Appropriate methodologies for evaluation need to be incorporated in order to develop the very limited evidence base for interventions of this nature. Some evaluation has been undertaken with an Aboriginal group in New South Wales based on comments from participants or their partners on changes that have occurred in their lives in relation to reform in behaviours such as domestic violence and moderation with alcohol and marijuana. It was reported that for this group the results have been encouraging (Franks 2000).

A participatory action research process (PAR) has been used by the authors of this report with men's group workers employed as research workers to work with men in their local community, with support from an external academic research team. This research has provided preliminary evidence that men's health groups in Indigenous settings can lead to social and behavioural change and that PAR is consistent with an overall program approach of enhancing participant's sense of control and mastery in their lives (Tsey, Wenitong et al 2004).

Section 3: Relevant mainstream theoretical frameworks

This section describes some of the underlying theoretical frameworks which influence or underpin the work of Indigenous men's groups. It may be useful for men's groups to more explicitly consider these frameworks to structure their programs to address Indigenous men's issues. These are the public health concepts of empowerment, health promotion, primary health care (and closely related concepts of community development, community capacity building, and resilience); and concepts from the mainstream men's movement, (including the development and rationale of mainstream men's groups).

Health inequalities and empowerment strategies

There are clear disparities between Indigenous and non-Indigenous people across key measures of socio-economic wellbeing, including health status, employment, education, housing, and contact with the criminal justice and care and protection services. Booth and Carroll (2005) estimate that between one third and one half of the gap in health status of Aboriginal and non-Aboriginal Australians can be explained by differences in socio-economic status. Internationally, people of lower socioeconomic status both within and between nation states, experience poorer health than their higher status counterparts for almost every major cause of mortality and morbidity (Booth and Carroll 2005).

Indigenous community leaders and health professionals have called for more innovative and empowering interventions that enhance people's capacity to take greater control and responsibility for their situation (Pearson, 2000; Oldenburg, 2000). Research suggests that the sense of mastery and control men have over their lives is a highly significant determinant of health (Marmot 1999). According to Syme (1998): *'the higher social classes have, from their earliest years, been given more training, opportunity, resources, and skills to deal with life problems; the lower a person's position in the social hierarchy, the less likely he or she is to have received these benefits'.*

The concept of control, as a social determinant of health, has been linked with the concept of empowerment (Syme, 1998). Empowerment has been defined as a process through which people reduce their powerlessness and alienation and gain greater control over all aspects of their lives and their social environment (Mullaly, 1997). It provides people with resources, opportunities, knowledge and skills - critical among these skills are the capacity to reflect and analyse one's situation (Ife, 1999).

Addressing empowerment or control can be undertaken within the context of a whole-of community or multi-level approach (Oldenburg et al, 2000). Oldenburg et al. (2000) have proposed a framework that incorporates this approach and groups health determinants into upstream, midstream and downstream level factors. Upstream factors include aspects of the social and physical

environments such as education, employment, housing, and taxation. Midstream factors include psychosocial processes and health behaviours, which reflect the way people experience and/or interact with their social and physical environments. They include the concept of 'control' or 'mastery'. Downstream factors include the neuroendocrine stress responses or the ways in which a person's experience or interactions with their environments translates into health or disease and illness (Oldenburgh 2000).

An important aspect of this framework is that there is no single entry point for tackling health inequalities. Policies and strategies need to be multilevel and multifaceted (Harvey et al., 2000). Such an approach requires interventions that engage and support individuals and groups to take greater charge of the conditions affecting their health and wellbeing (Tsey et al 2002, 2004). It also requires intersectoral collaboration and an organised response to the poorer health of disadvantaged groups (Oldenburg et al., 2000).

The concept of empowerment is central to health promotion and is closely related to that of community capacity building, defined as "*a generic increase in community groups' abilities to define, assess, analyse and act on health (or any other) concerns of importance to their members*." Program activities become the means to the end of increasing community capacity (LaBonte 2002).

Health promotion strategies

Based on the Ottawa Charter, health promotion is the process of supporting people and communities to increase control over their lives and improve their health. Health is seen as a resource for everyday life, not the object of living. It includes social and personal resources as well as physical capabilities.

Health promotion includes actions directed at:

- Strengthening individuals or increasing resilience, through interventions designed to promote self-esteem, life and coping skills, communicating, negotiating and relationship and parenting skills;
- Strengthen communities including initiatives to increase levels of social inclusion and participation and the capacity of communities to tackle issues which affect health; and
- Reducing structural barriers to health. This may involve policy and partnership initiatives to reduce inequality and discrimination and promote access to meaningful occupation, adequate housing, appropriate services and equal opportunity.

The five priority action areas (and examples of men's group activities might fit them) are:

- Building healthy public policy, for example, advocating for the establishment of a men's place, or involvement in the development of alcohol management plans;

- Creating supportive environments for health, for example, addressing issues of identity, self esteem and men's 'gifts', or exploring traditional cultural activities;
- Strengthening community action for health, for example, men's group meetings to mobilise men's interest in family violence issues, or community and sporting events;
- Developing personal skills, for example, supporting men to enroll in education/training programs, or having speakers at men's group meetings; and
- Reorienting health services, for example encouraging health services to improve access for Indigenous men, or providing health screening at men's group meetings, or advocating for a primary health care approach (Ottawa Charter 1986).

Health promotion focuses on the wider structures and actions that promote health rather than restricting itself to the individualistic focus of health education that emerged from the medical model of health. For strategies to qualify as true health promotion, one must first ask "*Is the activity empowering*?" (Raeburn, 2001). Most importantly, community people have to be at the centre of health promotion action and decision making processes for them to be effective (Raeburn, 2001).

Primary health care strategies

Comprehensive primary health care emphasises community-controlled social changes which impact on health, and in which medicine may play a minor role (Refkin and Watt cited in Wass 1994). Thus, it focuses on the process of empowerment and increasing control over all those influences which impact on health (Wass 1994:12).

As embodied in the Declaration of Alma Ata (1978), primary health care contains the following essential concepts:

- Equity;
- Participation and maximum community self-reliance;
- Socially acceptable technology;
- Health promotion and disease prevention;
- Involvement of government departments other than health through inter-sectoral collaboration;
- Political action;
- Cooperation between countries;
- Reduction of money spent on armaments and wars in order to increase funds for primary health care; and
- World peace (Wass 1994:8).

Tsey et al (2005) argue that true primary health care requires community-based intervention with a focus on enhancing individual, group and community capacity to take responsibility and control over life and health-related decisions.

Theories of masculinity

Gender is one of the major organising structures of social life. It is related to broad divisions of labour, social authority and control over resources, patterns of sexuality and emotional attachment, and identities. Groups of men and groups of women have differences in exposure to health risks, behaviour, interest and learning (Connell 2000).

Masculinity is a social construction. Research from the 1980s has found:

- There is no one pattern of masculinity that is found everywhere. Different cultures and different periods of history construct gender differently. Within a given setting, there will be different ways of enacting manhood, different ways of learning to be a man, different conceptions of the self and different ways of using a male body;
- Some masculinities are dominant while others are marginalised. In most situations, there is a desired or honoured form e.g. sporting heroes. The dominance of the "ideal" form may be quiet and implicit, but may also be vehement and violent as in the case of homophobic violence;
- Masculinities are defined collectively in culture and are sustained in institutions e.g. institutions of competitive sport;
- Masculinities do change, and can be consciously reconstructed (Connell 2000).

Traditionally, western masculinity expects men to be "*independent, strong, self-reliant, competitive, achievement-oriented, powerful, adventurous, and emotionally restrained*" (Levant 1996 in King 1999). The main outcomes for Australian men's health are:

- men have greater mortality from heart disease;
- men have a shorter average life expectancy;
- men have higher rates of injury from accidents, including industrial and motor vehicle injury;
- men and boys have higher suicide rates; and
- men have higher rates of alcohol abuse (Mathers 1996 in Connell 2000).

It has been shown that men in Western countries use health services at a lower rate, report less illness than women, respond to similar symptoms in differing ways, and are less ready to take health prevention action (Bellear 1996). '*Real men don't get sick, and when they do, real men don't complain about it, they don't seek help until the entire system begins to shut down*' (Sabo and Gordon 1995 cited in Adams 2001). In addition, men engage in more risk taking than women and are more likely to work in hazardous occupations (Wilson 1998).

Even in kindergarten, researchers have observed a link between some forms of masculinity and the practice of violence that was likely to lead on to further violence by boys. A study of 268 children in four Australian early childhood centres found that significantly more boys were violent, and of the violent boys, they carried out many more incidents than the girls who were violent. Some styles of violence (threats, throwing objects and hitting with objects) were almost unique to boys (Main 1998).

However, men are not a homogeneous group. Although patriarchy, through social and cultural practices, empowers men over women, the power distribution is uneven and differential, with some groups marginalised to such an extent that their lives may be endangered (King 1999). Men from low socio-economic status (including most Indigenous men) are often unable to achieve a healthy lifestyle in a safe environment due to their lack of finance, knowledge and skills to acquire the essential prerequisites of good health—such as suitable housing, education, nutritional diets and so on. They also have an increase in lifestyle risk factors such as smoking, obesity, harmful drinking patterns and lack of exercise. Consequently, men from a lower socio-economic status suffer higher mortality, higher levels of disability, and have a higher likelihood of having a chronic or recent illness (National Health Strategy 1992).

There has been little published analysis of gender definitions for Aboriginal men. One article, however, explores the importance of football as a marker of masculinity for young working class and Aboriginal men. Mills argues that some men become over-involved in football and are willing to undertake risk taking behaviour and endure pain and injury for the perceived benefits of confirmation of one's manhood and sexual desirability (Mills 1997).

Mainstream men's movement

In mainstream Australia, there has been an increasing awareness since the 1970s of the possibility of change in gender relations, with a goal of making the full range of gender symbolism and practice available to all people (Connell 2000). This resulted from the rise of feminism as a diverse collection of social theories, political movements and moral philosophies that aims to understand the nature of gender inequality and focus on gender politics, power relations and sexuality. Changes have included:

- civil rights such as women's suffrage, equal pay for equal work, the right to initiate divorce proceedings, contraception, safe abortions etc;
- more common use of non-sexist language;
- change in power relationships within heterosexual relationships;
- effects on religion, such as ordination of women as clergy, rabbis and cantors; embracing new forms of religion; and an

- effect on moral education, and women's role in the moral education of children.

Radical feminists have advocated that oppressive patriarchy is the root cause of most serious social problems and is more fundamental than oppressions related to class, ethnicity, religions etc. Other feminists have maintained that there may be social problems separate from or prior to patriarchy and see feminism as one movement of liberation among many, each affecting the others. Both Black American and Indigenous Australian feminists, for example, have criticised feminism as being dominated by white women, and have advocated for a "post-colonial" feminist analysis which considers that gender oppression may come second to racial or class oppression for black women (Wikipedia 2005, Huggins 2003). In reference to family violence, for example, (white) Australian feminist, Heather Nancarrow states "*What I have learned is just how profoundly the justice system and feminist legal reforms have been in the service of white women. The feminist movement has been, and continues to be, committed to the inclusion of Indigenous women and their interests in the development of strategies to deal with domestic and family violence. But Indigenous women's experiences cannot be simply added onto the dominant feminist paradigm. Instead, effective strategies must make Indigenous women's standpoint the central standpoint*" (Nancarrow 2003).

Since the 1970s, men's groups have emerged in a supportive response to feminism and to assist men in "*undoing the damage inflicted by their socialisation into a warped masculinity*" (Achilles Heel Collective 2005). The early men's liberation groups believed that masculinity was in crisis, and that the crisis would drive change towards the annihilation of masculinity as we know it and it's replacement with some kind of androgyny where the characteristics of both male and female are seen as being suitable for either sex. In the 1990s, two "men's movements" (which originated in the United States) gained some following in Australia. One was based on new age therapy and the other on right wing evangelism. Both raised questions about men's identity and offered remedies for troubles in men's lives. There were also vigorous public debates about men's violence, men's health and boys' supposed "disadvantage" in education (Connell 2000).

Connell describes four main structures through which men (and women) have attempted to work towards greater justice between the genders. These are:

- changing power relations such as men's dominance in politics, the professions and management, and ending violence against women;
- changing economic relations such as equalising incomes, sharing the burden of household work, and equalising access to education and training;
- changing emotional relations such as ending homophobia, developing reciprocal heterosexual relations and challenging the association between masculinity and violence; and

- changing the symbolism of dominance by challenging stereotypes and making cultural resources available to disadvantaged groups (Connell 2000).

However gender politics is unavoidably complex. It is commonly assumed that a progressive politics of masculinity must take the form of a social movement such as the gay movement, labour movement or civil rights movement. But Australian men as a group and heterosexual men in particular are not oppressed or disadvantaged, and attempts by men to address sexism have been subverted towards a concern about being "positive" about men and "masculinity therapy" (Connell 2000). Paradoxically, Connell reasons, to fight for justice in gender relations often means doing the opposite of the things that would create a "men's movement". That is, tackling issues that inevitably divide men rather than unite them, such as homophobia, affirmative action for women, equal pay, sexual harassment and violence.

Rather than a men's movement, Connell suggests that men are likely to be detached from the defense of patriarchy in small numbers at a time, in a great variety of circumstances. Hence the aim should be for a variety of struggles in diverse sites employing alliance politics or overlapping interests or commitments between different groups e.g. the Mardi Gras parade in Sydney, integrated sports in schools, fathers taking greater responsibility for the care of young children (Connell 2000).

Not surprisingly, Aboriginal men appear to have had minimal or no involvement in mainstream anti-sexist politics or approaches. In some cases, the work of Indigenous men's groups can be seen to support Connell's suggested strategy of detaching men from the patriarchy in small numbers at a time. Examples of this are men's group's work in preventing men's violence and its consequences; and in supporting fathers who take the primary responsibility for the care of their children (while their partner's work or study) (McCalman et al 2006, 2006a). In Yarrabah, men's group members also expressed an increasing willingness to do a greater share of housework (Tsey et al 2005).

At times, however, exploring issues of gender and politics has been seen as less important than addressing their own disadvantage, which (based on some indicators) is even more extreme than that of Indigenous women. For example, our evaluations have documented men's group dissatisfaction that women's services receive more funding, health services tend to be dominated by women, women are advantaged in family law, and that women may not value and appreciate men (a continuation of their historical experience of disempowerment) (Tsey 2005, McCalman 2006, 2006a).

An analysis of the role of black men in the (white) men's movement in the United Kingdom may also have parallels with the position of Indigenous men in Australia. Black men in a racist society are denied social, educational and

economic advancement (the dominant measures of masculine success in a white patriarchal culture). But black men aspire to these kinds of success in order to obtain self-esteem and redress their position of marginalisation and powerlessness. The prevalence of Christian values reinforces the assertion of traditional masculine attitudes and traditional roles for women in personal relationships and can also foster homophobic attitudes in the black community. Black women, relative to black men, have a higher level of educational success and employment opportunity, giving them a greater degree of economic independence. Some black men have claimed that this has further emasculated them. In addition to these pressures, black men can fear being perceived as less than “real” men (Scott 1992).

Consequently, some black men are reluctant to accept that they have and use (or misuse) power over others, particularly women, and hence may assert power in one of the few spheres available to them – their personal relationships. The attempt (particularly of lower class black men) to mitigate their low self esteem and feelings of powerlessness at being denied the most basic rights and opportunities in society can result in the abuse and misuse of women and children (Scott 1992).

Mainstream men’s groups

Internationally, the men’s movement has brought the emergence of a range of ‘self-help’ and ‘self-improvement’ initiatives, including men’s conferences and men’s groups. A decade ago, it was estimated that there were more than 300 mainstream men’s groups in Australia, created through neighbourhood networks, community groups, at work places, or through churches (Biddulph 1995). Like Indigenous men’s groups, the intention of many of these groups is to create a safe place, providing comforting feedback and to explore relevant men’s issues (Jesser 1996). They aim to be therapeutic and supportive, providing an opportunity for reflection and emotional expression; a safe space where men can explore concepts and stereotypes of masculinity which constrain personal happiness and free expression.

The groups assist men to look to each other for emotional support in dealing with changed social expectations of both men’s and women’s roles. Men are now expected to be more egalitarian, flexible, communicative and caretaking, yet at times, also assertive or aggressive. Many boys are growing up in single parent families without intimate contact with an adult man. Some groups have an overt philosophy of helping men to be powerful and forceful without being abusive (Garvey 1995). Some groups are exploring ways to reintroduce rituals, such as a meaningful passage into manhood, and offer a range of activities, for example, the opportunity to talk and reflect on experience, week-end camps and other outings, yoga, meditation, shared meals, and family sessions where partners and children are invited to be involved. Other groups have a specific focus such as parenting, relationships and health issues.

There is much anecdotal reporting of the value of group programs but possibly in part due to the informality of many groups, it would appear that there has been little rigorous evaluation to date. Kyriacou, a Victorian general practitioner, for example, reported positive outcomes from three men's support groups and predicted that if such groups were to become more common, there would be "*fewer referrals, better family care, fewer lives lost, higher integrity doctor-patient relationships, less litigation and extraordinary government savings*" (Kyriacou 2002). He was unable to continue the research because the small size of the groups (to maintain the group's intimacy) meant they were unable to receive organisational sponsorship.

In the absence of rigorous evaluation, it remains unclear exactly what impact men's groups might be having on men's health and wellbeing, and whether some approaches are more successful than others. Therapeutic groups have been criticised because members may end up seeing themselves as victims, rather than members of the dominant gender and challenging sexism (Achilles Heel Collective 2005). Facilitators need to be very clear about their values and attitudes in relation to the use and abuse of power in relationships. Minimising, denying, and blaming done by men in relation to their violence is endemic. It can be very challenging for facilitators to maintain a position of not colluding with such attitudes, even sub-consciously (Anderson 1998, Atkinson 1999, King 1999). Some groups have used positive male and female role models to counter this tendency (Lampasona 1994) or a female "witness" to participate in groups.

Although there is currently little explicit anti-sexist work being done in men's groups, the few notable exceptions are to be found in the fields of anti-male violence and youth work (Achilles Heel Collective 2005). Effective behaviour change programs have been developed and implemented within men's groups to work with men who use violence against family members. They also aim to assist workers to avoid risk and work responsibly with these men (Younger 1995; Frances 1997). A number of programs in Australia are based on the Duluth Domestic Abuse Intervention Project model which has been evaluated extensively in the United States demonstrating the project's effectiveness in enhancing victim safety and holding offenders accountable for their behaviour. However, the appropriateness of using the Duluth model for working with Indigenous Australian men has been questioned.

Section 4: Program interventions

This section describes a range of program interventions which Indigenous men's groups might wish to consider in developing strategic plans or priorities for their work. Where possible, the review describes which of these areas are effective and their limitations for adoption by men's groups.

PROGRAMS TO WORK WITH INDIVIDUAL MEN AND THEIR FAMILIES

Counselling, leadership and personal development programs

Indigenous people are confronted with a high burden of stress and worries. Alcohol and drug use; violence between family and community members; emotional problems such as depression, problems sleeping, anxiety and grief; and health problems all contribute (Deemal 2001). Aboriginal and Islander men have experienced a history of loss, trauma and grief including loss of land; loss of traditional ways; loss of roles as hunter/providers /warrior/teacher of young men; loss of health; lack of recognition of human status (by Terra Nullius) and loss of freedom. Culture was undermined; self-determination was lost; and children were removed (Indigenous Youth and Men's Health Conference, Oct 1997). The roles of Aboriginal men have been devalued and loss and pain is transmuted into frustration and anger (Hunter 1998). The consequence has been a devastating loss of self esteem and self respect, loss of culture and country and spiritual wellbeing (Briscoe 1999, Spry 1999).

Men's groups have responded to men's need of making sense of their own lives by offering individual counseling services and group leadership and personal development programs. One example is the Family Wellbeing empowerment program, developed by "stolen generation" Aboriginal people in Adelaide. The program is based on the idea that a holistic approach encompassing the material, emotional, mental and spiritual, leads to self empowerment and ultimately gives people the communication, conflict resolution and other qualities and skills necessary to take greater control and responsibility for family, work and community life. Personal development workshops provide opportunities for participants to build trusting relationships, think about their individual needs and aspirations, and develop life skills, strategies and support mechanisms to help each other meet those needs. Specific topics include group agreements, leadership, basic human needs, relationships, life journey, conflict resolution, emotions, crises, beliefs and attitudes, and sensitivity as a leader. Step 2 of the Family Wellbeing process involves supporting participating groups to collectively address priority community issues identified from the personal development training.

Evaluation of the Family Wellbeing Program has demonstrated program participants have significantly enhanced their self worth, resilience, ability to reflect on the root causes of problems, problem-solving ability, as well a greater

belief and an enhanced sense of hope that their situation can change. Evidence is also emerging of a ripple effect of increasing harmony and capacity to address issues within the wider community, e.g. poor school attendance rates, critical housing shortage and the creation of work opportunities for men (Tsey, Patterson et al. 2002, 2004).

A similar Canadian program, the Family Life Improvement Program (FLIP) of the Native Counselling Service of Alberta, uses processes of group discussion, storytelling, role-playing and personal sharing to assist people to explore issues. These include family and social relationships, drugs and alcohol, the emotional growth of children, positive opportunities for personal development, and how to access public information and resources. Participants develop skills in parenting; self-esteem building; interpersonal communication; self-help and finding information; locating positive life opportunities; respect, consideration and caring for others; constructive use of leisure time; and dealing with government agencies (NCSA 1985 in Hazlehurst 1997).

One response to emerging research about the effects of transgenerational trauma in Aboriginal peoples and the resultant symptoms of violence has been to adopt trauma recovery treatments within perpetrator programs. The Queensland self-help group, We Al-li (Fire water), for example, endeavours to assist people heal past traumas and thus break the cycle which manifests as violence against self and others. The program addresses six stages to trauma recovery:

1. Creating a safe environment;
2. Finding and telling the story;
3. Feeling the feelings
4. Making sense of the story;
5. Being prepared to work through the multiple layers of loss and grief to an acceptance;
6. Reclaiming the sacred in the self (Atkinson and Atkinson 1999).

"*It's only when we start to do our own healing work that we can truly start to resonate, we feel the pain of the other because it's not as bad as all that*" (Judy Atkinson)

"*I am inspired by the knowledge that we can take this pain, work with it, recycle it, transform it so it becomes the source of our power. That's what makes us strong, when we own ourselves, when we know who we are, when we know how we have been formed. How when I get on my feet and walk out there because I'm angry and immediately know what that anger is, and it's not at what has just been said but it's way back there, that's power. Because then I'm empowered or I'm able to stand up and speak from that place of real knowledge*" (bell hooks, in Thompson Ed 1999 p 147)

Parenting programs

The family is the central point to Indigenous cultures. Although there are individuals and families who are resourceful, supportive and caring parents, many Indigenous families and children are facing huge stresses as they struggle to cope with disadvantage and, in many cases, they are not coping with this stress. Particularly in remote communities, children and young adults are being raised in environments of heavy alcohol use, devolution of responsibiity for nurturance and sustenance to older siblings or older abstinent women, and with structure and discipline often inconsistent or absent (Hunter 1999). Indigenous family violence also continues to have significant negative social and economic impacts on Indigenous people.

Indigenous adult males face enormous challenges and pressures in their parenting, in particular of male children and youths, who are their special responsibility: whether as fathers, grandfathers or uncles. Their low levels of employment, educational disadvantage, poverty, high rates of illness and injury, and imprisonment all reduce their parenting capacity. The historical dispossession and disempowerment of Indigenous men have impaired their self-esteem and confidence to carry out their parenting and teaching responsibilities (Male Health Policy Unit 2002).

There has been little systematic investigation into the needs of young Indigenous men in their fathering roles. For many young males who become fathers, the compounding issues of being adolescent, Indigenous and male have serious implications for positive outcomes in their role as fathers (Hammond, Lester et al. 2004).

Leadership and personal development programs such as the Family Wellbeing Program described above have been used by men's groups to address issues associated with parenting. Government funded projects to strengthen Indigenous families aim to:

- recognise and promote the importance of strong families among Aboriginal and Torres Strait Islander people;
- provide information about parenting and family wellbeing;
- promote culturally appropriate quality family support mechanisms that recognise the diversity of Aboriginal and Torres Strait Islander families; and
- provide support and assistance for the younger generation of Aboriginal and Torres Strait Islander people to participate in family life and build strong families and communities for the future (Department of Families and Communities 2005).

In some communities, men's group meetings have been used to provide informal support to men for relationship and parenting issues. There is a sense that

increasingly, some men are staying home and looking after children while their partners go out to work. This can be isolating and men's groups have identified that they can play a role in supporting such men (McCalman, Tsey 2006; 2006a).

Work with young men and boys

The Indigenous population is young, with 39% males being less than 15 years old compared to 20% of non-Indigenous males (ABS 2003 in Australian Indigenous Health InfoNet 2005). Almost half (46%) of Aboriginal and Torres Strait Islander people in Queensland are under 18 years of age (Fitzgerald 2001). Every 100 Indigenous adults of working age in the Northern Territory were responsible for 66 children compared to 32 in the non-Indigenous population (d'Espaignet et al 1998 p2).

In traditional culture, young men had a clear passage to manhood through a culturally appropriate system of initiation. With the introduction of segregation and assimilationist policies and the institutionalisation of Aboriginal people, they were forbidden to practice or participate in traditional rituals and customs. Miller (cited in the Burdekin report, 1993) observes that the pain and bitterness of these memories are passed on from generation to generation resulting in feelings of hate, anger, frustration, grief, depression and alienation (Adams 2001).

There is little information about how health knowledge and practices are currently transmitted from Aboriginal men to boys (Laws and Bradley 2003). Brian McCoy describes *kanyirninpa* or "holding" where older generations assume the responsibility to care for and look after younger people as a deeply embedded value amongst desert Aboriginal peoples. When boys become men, they seek to be held by older men (rather than women) and are inducted into the social meanings and behaviours of desert male adulthood. Despite the dislocation of colonialism and mission activity, desert Aboriginal people emphasized the continued value of "holding" as an essential ingredient for social and emotional wellbeing. McCoy identified particular aspects of male holding within the social contexts of petrol sniffing, football and prison (as well as risks to men's health) (McCoy 2004). In less traditional communities, this process may be less clearly defined.

Indigenous children and adolescents are at risk as both perpetrators and victims of violence, alcohol use, sexual activity, sexual violence and crime at an early age (Cunneen 2002). Children who have experienced violence are also at much higher risk of becoming perpetrators and have a far greater acceptance of violence as a means of control. Indigenous children come into contact with the care and protection system at a greater rate than non-Indigenous children and are increasingly represented at the more serious stages of intervention (Human Rights and Equal Opportunity Commission 2004). Working with young people is perhaps the most important means of ensuring that attitudes towards family violence are changed in the long run (Cunneen 2002). The transgenerational

cycle of domestic violence has been well documented (Blanchard 1993, Tomison 1996) and, given the extent of current violence in Indigenous communities being perpetrated on young people it would seem that without urgent intervention and prevention measures another generation may continue in the cycle of violence.

For young people without a sense of self-worth, alcohol, drugs, or crime provide a temporary sensation of "being somebody" or gaining some fleeting sense of power over a system which is overwhelmingly stacked against them (Atkinson 1993; Hazlehurst 1997). The juvenile justice system is underpinned by the idea that most youth mature out of crime, and that, while still being held responsible for their actions, as minors their responsibility under the law is mitigated by age (Atkinson 1993). But Police data for Victoria indicates that Aboriginal people's contact with the juvenile justice system commences early and there is a continuing high level of contact with the system, particularly for Aboriginal males. Since 1997, Indigenous juveniles have constituted at least 42% of all incarcerated juveniles, despite constituting 4% of the total juvenile population (Human Rights and Equal Opportunity Commission 2004). Longer-term consequences include the likelihood of adult incarceration (Mackay 1996).

Hence Indigenous crime prevention programs need to combine education with recreation and esteem-building activities. The whole environment of youth offending needs to be considered with parents and young people invited to discuss family life, alcohol addiction and other problems which they share (Hazlehurst 1997). There are few violence prevention programs designed specifically for Indigenous young people (Cunneen 2002), but those that exist include reinforcing positive social values through school-based work, or intensive case-work with at-risk youth and their families (Thompson 1999).

Many Aboriginal adults and children today are living without a sense of security in their daily life or any sense of their own future. Many Aboriginal people would say that they believe their life will not offer real opportunities for work, for success or for change. Developing a "vision for the future" became an important part of the community healing process in Canadian indigenous programs (Hazlehurst 1997). Hazlehurst suggests that community groups can help to discover unrecognised local capacities, escalate self-esteem and demonstrate to individuals the strength to be gained by those who work supportively together. She recommends that communities creatively visualise future options by asking questions such as:

- What would our communities be like if free of violence and addiction?
- What sort of future would we like to see for our men/women/children?
- What new skills/programs do we need to bring this about?
- What raw materials and human resources do we already have?
- Who outside the community can help us achieve our goals? (Hazlehurst 1997).

Sport and recreation programs

The achievement of Aboriginal men in sport has been a source of pride and leadership. Sports and fitness programs are an important part of Aboriginal community development, contributing to both physical and emotional wellbeing. This is especially true for the health of young people (Williams and Kakakios) 2002).

Indigenous men's groups have developing sporting and recreational strategies such as organising sporting carnivals and events. Australian Rules Football, for example, provides an energetic, social and geographical space for exercise, discussion and male group activity. McCoy (2004) describes the skills needed within the football arena as similar to those men have developed and learned through hunting, including concentration, coordination and focus of many senses. Football and other sports are activities where male sociality is reinforced, exercise undertaken, values reinforced, skill, courage and confidence developed and interaction with the wider male world occurs. However, sport can also have negative consequences such as violence and absence from families (McCoy 2004).

Culture, tradition and spiritual recovery programs

The Aboriginal and Torres Strait Islander holistic view of health as life-death-life observes the connectedness between the family, land and community. An ethnographic study of how Aboriginal and Torres Strait Islander men cared for their health (Adams 2001) found that men were weighed down by the denial of traditional roles, lack of support systems, lack of culturally appropriate services and absence of gainful employment. They used negative strategies to deal with health issues including self-destruction and non-disclosure.

The only "strategy of hope" that was utilised was a return to country/culture. The men felt that to assist in caring for their health, they needed to go back to their roots and capture the culture they had lost. Aboriginal men expressed the need to have areas set aside to educate younger men about traditional systems, initiations and obligations of Aboriginality. They felt that it should also be available for older men who had lost or had not been taught the traditional ways. The men felt that they needed to plant the cultural belonging seed early so that younger men would be given the right advice to help structure positive adult behaviour (Adams 2001).

The link between individual and cultural continuity was demonstrated in a Canadian study of youth suicide. The authors found that Aboriginal communities which had succeeded in taking steps to preserve their heritage culture and to recover some measure of control over the institutions governing their own collective future were also dramatically more successful in insulating their children against the risks of suicide (Chandler and Lalonde 2003).

There are a few examples of programs designed to encourage a cultural and social revival. Trudgen, for example, calls for five key strategies that, if addressed, could have the greatest impact in assisting Yolnu people of Arnhem land regain control of their lives. In this context, these are:

1. Take the people's language seriously so that Yolnu are not intellectually marginalised, understand court hearings and so on. This could occur through establishing research to chart the Yolnu Matha languages, set up a media outlet in language, and teaching language to dominant culture personnel who work in Arnhem land.
2. Train dominant culture personnel through cross-cultural orientation, a higher level of language and cross-cultural training for educators and trainers, and a very high level of training for a small group of specialist educators.
3. Approach education and training in a different way to meet the real learning needs of Yolnu.
4. Replace existing programs with programs that truly empower the people by returning responsibility and control to Yolnu.
5. Deal with some basic legal issues such as recognising traditional law (Trudgen 2000).

Internationally, when Indigenous communities have undertaken programs for socio-cultural and spiritual recovery, over a five to fifteen year period, significant economic recovery followed. The social, cultural and spiritual wellbeing of Indigenous peoples in Canada and New Zealand are seen to go hand in hand with the process of independence, and are incorporated with ease into the official vocabulary (Hazlehurst 1997).

Suicide prevention programs

For the period 1990-1996, the suicide rate for Indigenous males was twice that for the non-Indigenous population. For teenagers and young adult males aged 15-29, the rate was nearly four times higher. In contrast, the rate for Indigenous females was similar to that of other Australian females (Hunter 1999). In some communities which experienced waves of suicide, rates have significantly abated since 1996. These trends have not been adequately explained, but may be related to Chandler and Lalonde's (2003) Canadian findings which demonstrated that increased suicide risk in Canadian adolescents (Indigenous and non-Indigenous) is strongly related to a poor sense of personal persistence. Individual and cultural continuity are strongly linked. Where Canadian Aboriginal communities succeeded in taking steps to preserve their heritage culture and to recover some measure of control over the institutions governing their own collective future, they were also dramatically more successful in insulating their own children against the risks of suicide.

Research into the causes of suicide indicates that the combination of stressful social circumstances with emerging symptoms of depressive illness can produce

suicidal impulses. Cultural factors may influence the choice of suicide method, with Aboriginal people being 10 times over-represented among deaths by hanging. People who kill themselves by hanging do so privately and at times and places that provide little possibility of their being found before they die. For this reason, if this cause of death is to be prevented, interventions must occur at an earlier time (Kosky and Dundas 2000).

Basic preventive measures include:

- Young people who threaten suicide should be given priority for specialised mental health assessment. Threats should be treated as potentially life-endangering situations;
- Young people who face court hearings need personal support as this is a very stressful time;
- People who have been treated for psychiatric illnesses or attempted suicide need adequate medical follow up, especially if they live in rural areas;
- Young people who are feeling depressed should know that treatment is available;
- Barriers to accessing services should be addressed (Kosky and Dundas 2000).

Alcohol-related programs

Alcohol and drug use is often a response for mental and emotional suffering, such as anxiety and depression (Najman in Male Health Policy Unit, 2000), which arise from the stresses of the lived realities of poverty, disempowerment and hopelessness.

Alcohol-related problems are most commonly a problem for men. While a large proportion of Aboriginal Australians do not consume alcohol, those who do frequently drink to harmful and hazardous levels, showing severe alcohol problems and often associated with family conflict and violence (Kowalyszyn and Kelly 2003). The availability of alcohol contributes to the major illness conditions and high mortality rate of Indigenous people (D'Abbs 1996 in Adams 2001).

Once dependence on alcohol is established, drinkers tend to reduce their performance of social and cultural roles, including parenting. The separation of Indigenous males from their families and communities through moving to towns with readily available alcohol, sobering up shelters or imprisonment, impairs the male parenting available to indigenous children and youth from their fathers, grandfathers and uncles (Male Health Policy Unit, 2000). Substance abuse also hinders the transmission of cultural knowledge across generations (Cape York Institute 2004).

An estimated 90 per cent of violence is alcohol-related (Hazlehurst 1997) and substance abuse is the main cause of Aboriginal over-representation in the criminal justice system (Cape York Institute 2004). Pearson comments: *A very great proportion of the violence in our communities is associated with grog – the court convictions and clinic records show this clearly. If we get on top of our grog and drug problem, we will get on top of the worst of our violence problem. It is clear that strategies to combat violence will not get very far if they are not primarily aimed at our grog and drug problem*" (Pearson 2001). Hazlehurst states that *"without doubt alcohol has become the primary cause of family and community disruption in communities*" (Hazlehurst 1997).

Pearson (2001) argues that the grog and drug problem must be dealt with prior to dealing with either violent or non-violent crime, improving health or life expectancy, addressing the over-representation of Aboriginal people in the criminal justice system or preserving culture. "*What our people need more urgently than an expansion of the health care system is an immediate dismantling of the passive welfare paradigm and an end to permissive thinking about grog and drug policy*" (Pearson 2001). Homel et al, however, speculate that the best point of intervention may not be alcohol use but the aspects of dependence (such as lack of meaningful employment) that are most salient for a given individual (Homel, Lincoln et al. 1999). Others view the root problem as "having lost our spirit", and see programs which focus on specific factors such as alcohol as bandaid solutions. They argue that the priority should be focused on a cultural and spiritual revival (pers comm. Bradley Baird 2005). "*When people are sober and well, there isn't anything we can't do. Heal the spirit and you will heal the problems*" (Canadian Indian worker quoted in Hazlehurst 1997). There are synergies between these approaches, and the focus of community based programs should be determined by perceived priorities at community level.

There are three main direct alcohol prevention strategies. Primary prevention strategies attempt to prevent people drinking or prevent excessive drinking by informing people about alcohol and drugs or encouraging responsible drinking. Alcohol education or instructions about the harmful effects of excessive alcohol consumption is <u>not</u> recommended as a treatment strategy for alcohol dependence because it is not personalised to the drinker (Mattick et al 1993 in Brady 1998). Hence education about the harmful effects of alcohol and other drugs should only be provided as part of other community activities (Brady 1998).

Secondary prevention (or early intervention) includes brief intervention, or talking directly to people about what drugs and alcohol are already doing to their bodies and their lives. Personal advice from a health worker or doctor can have a strong influence on the individual (Brady 1998). While Pearson acknowledges the value of screening and doctors' interventions, he also advocates for both compulsory as well as voluntary rehabilitation. He observes that addicts are likely to consider voluntary rehabilitation only when the damage has already been done (directly by

introducing other people to addiction and indirectly by causing chaos within the community) (Pearson 2003).

Harm reduction acknowledges that it is not likely that we will ever prevent people from using alcohol and drugs completely, so there should be a focus on preventing people from harming themselves or others. Strategies include night patrols, preventing alcohol-related injury, sobering up shelters, Alcohol Management Plans, random breath testing, and foetal alcohol management plans (Brady 1998). Pearson argues that the ideology of harm minimisation refuses to tackle the addicts and their addiction as the essential problem and that those who say that we will have to "learn to live with alcohol" need to understand that there must be fundamental, radical changes to the established habits and cultures of Aboriginal drinking if this is to happen (Pearson 2003).

Drinking behaviour is socially learned and differs according to the situation and environment. Pearson argues that the currently established cultures of Aboriginal drinking will always lead to abuse because people drink to get drunk. The aim should therefore be abstinence and zero tolerance of abusive behaviour (Pearson 2002).

Pearson describes a comprehensive six-point strategy for addressing substance abuse, including:

- Rebuilding a social, cultural, spiritual and legal intolerance of abusive behaviour (or rebuilding the true care and respect of our ancestors) by restoring Aboriginal law through community justice groups, developing community justice agreements to action law enforcement and justice strategies, spreading awareness of substance abuse, developing a new method of policing, and instituting zero tolerance for illicit drugs;
- Controlling availability and supply by developing alcohol management plans, and restricting takeaways and importation of alcohol;
- Managing money by implementing personal and family income management programs, matching account programs, credit unions, purchasing facilities, gambling controls, compulsory income management orders, and fines and restitution for damage;
- Managing time by providing interventions to break the social habits and routines of addiction, stimulating voluntary activity and initiatives, supporting cultural transmission and survival and sport and recreation activities, and increasing access to 4 wheel drive vehicles and travel, exchange and vacation clubs;
- Treatment and rehabilitation by screening and doctors interventions, support services for treatment and rehabilitation programs, compulsory attendance at treatment and rehabilitation programs, developing AA counselling methodology, and implementation of rehabilitation programs for people in prison custody and leaving custody; and
- Fixing up the home and community environment by clarifying and ensuring adherence to local government responsibilities for safe, well maintained

and aesthetic environments, reforming CDEP to support families improve home and community environs, developing a “pride of place” strategy, community history, culture and memorial projects and supporting home ownership (Pearson 2001).

Improve access to health services (including counselling/mental health)

Despite the poor health of many Indigenous men, they often do not access health services, care and treatment when they need them. Inadequate resourcing and failures of health systems to identify and address specific Indigenous needs mean that access to generalist health services is poor, and access to specialist and specific services worse. Barriers for men to access health services, particularly in remote areas, include physical, economic, cultural and personal factors, availability of transport, distance to and availability of services, possession of private health insurance and proficiency in English. Many Indigenous males express lack of confidence and embarrassment in using existing health services in their communities to present and discuss their health concerns, and may also be reluctant to go to a hospital because they see it as a place of dying and not a necessarily place of healing (Adams 2001).

Men often feel that women dominate health services and that their core business is principally the concerns of women. The lack of employment of male health workers, or their subordination to female non-Indigenous nurses or doctors aggravates this situation (Adams 2001). Between 2000 and 2001, there were 197 male Aboriginal health workers (AHW) and 427 female AHWs nationally (WPATSIMHWBRC 2003). Feedback from the Aboriginal and Islander male health conferences suggest that males are less likely to present at a health service, especially where no male health worker is available (WPATSIMHWBRC 2003). Data from the community-controlled health sector shows that in 2000/01, approximately 40% of Indigenous episodes of care were provided to men and 60% to women (AIHW and Statistics 2001).

Ethnicity of the health workers is also a significant factor. In general Aboriginal and Torres Strait islander people access hospital and community health services at a greater rate than the general population (Deeble 1998), perhaps related to the provision of services by Indigenous workers (97% AHWs and 92% substance use workers are Indigenous). In contrast, Indigenous people access GPs, medical specialists, pharmacists and nursing homes at a lower rate than the general population (with 99% GPs, 94% dentists and 100% specialists being non-Indigenous) (WPATSIMHWBRC 2003).

Most Indigenous people live in rural and remote areas (AIHW and Statistics 2001) but the supply of health professionals per head of population decreases with increasing rurality. Data from the ABS and AIHW indicate that more than half of all Indigenous people living in rural areas have to travel more than 50km to hospital. People in rural areas also have less access to specialist services such

as mental health, health promotion and diabetic services, and sexual health clinics (WPATSIMHWBRC 2003).

In most, if not all, consultations amongst NT Indigenous males about their health issues, men identified a need for special places and facilities in their communities where they will be able to discuss and address their own health issues. Many men expressed their alienation from existing health services and the places where they are conducted(Adams 2001).

Strategies to address men's poor access to health services have included:

- attracting and keeping Indigenous male health workers;
- establishing special male health places and facilities. Ideas about these places range from facilities for special clinical services, through special places for discussions and education, to places and facilities where males pursue their health and other interests such as recreation, training and work. The Indigenous males in each community must define their own concept and purposes of such a facility, and be engaged in planning its establishment; and the activities which will take place; including the ways and extent of collaboration and cooperation with generic or female oriented health facilities and services. Consultations at Nyirrpi in 1993, for example, identified that men wanted a place where they could work on their cars, get training and talk about health and other issues (Mitcalfe 1994 in(Male Health Policy Unit 2000)
- action addressing "non-medical" problems (Bartlett 1998);
- Development of partnerships between Aboriginal health workers; and mainstream health services to improve access to health services (Martinez, Carter et al. 1999).

Work with the criminal justice system

Crime prevention programs

In every society, for all social groups, for all races and both sexes, at all historical times, the tendency to commit crimes and other risk-taking behaviour rapidly increases in early adolescence and peaks in late adolescence and early adulthood. Then it rapidly decreases through the 20s and 30s and levels off during middle age. Kanazawa and Still (2000) propose an evolutionary psychological theory of male criminality. They suggest that the intense intrasexual competition for mates among young men has produced a psychological mechanism that compels them to commit interpersonal violent crimes and property crimes in their attempt to gain reproductive access to women. Psychological mechanisms evolved during the Pleistocene epoch (which ended about 10,000 years ago), when there were no police, courts or third party interventions in interpersonal conflict. This theory may help to explain the criminological evidence that lower class men, unpopular boys and smaller boys commit more serious violent and property crimes, needing to resort to criminality

in order to acquire resources and consequently reproductive success (Kanazawa and Still 2000).

Despite the universality of the age/crime relationship, there is no standard model for crime prevention programs. Frameworks need to be broadly based but focused on the general outcome of dealing with family violence and/or other crime, for example, some communities may focus on controlling the consumption of alcohol; other on alternative dispute resolution and community input into pre-court sentencing. Many community organizations, agencies and programs contribute to crime prevention although this may not be their core activity (Cunneen 2002).

Homel et al, in their review of developmental prevention strategies, claim that Aboriginal law breaking is not exclusively an Aboriginal “problem” but the product of circumstances created by history, social policies and structures, local conditions and criminal justice practices. Risk factors for crime by Aboriginal people include forced removals, dependence, institutionalised racism, cultural features and substance use. Protective factors include cultural resilience, personal controls and family control measures (Homel, Lincoln et al. 1999).

Developmental prevention models involve intervention early in the developmental pathways that lead to crime and substance abuse. They emphasise investment in “child friendly” institutions and communities and the manipulation of multiple risk and protective factors at crucial transition points such as around birth, the preschool years, the transition from primary to high school and the transition from high school to higher education or the workforce. A study by McKendrick et al (1992) of 112 randomly selected Aboriginal participants found that those who grew up in their Aboriginal families, learned their Aboriginal identity early in life and regularly visited their traditional country were significantly less distressed (Howells, Day et al. 1999).

Working with offenders

When Indigenous people are convicted of crime, they are most over-represented in offenses involving violence, public order, motor vehicle offenses and property damage. Indigenous people tend to come before the courts for more serious property crimes including break and entering, and stealing motor vehicles, than non-Indigenous people. They are also significantly over-represented before the courts for public order offenses and offenses involving violence.

Australian Indigenous people are considered to be one of the most imprisoned populations in the world, comprising 22.7% of the Queensland prison population but only 3.1% of the population. The Indigenous imprisonment rate has increased from 20.6% ten years ago (Walsh 2004, Aboriginal and Torres Strait islander Social Justice Commission 2002). The vast majority of Indigenous prisoners are serving short sentences of 12 months or less (generally for minor offences such as drunk and disorderly behaviour and property offences) which means they are

less likely to receive case management services (Walsh 2004). A significant proportion of Aboriginal people received into prison are there for secondary offences such as defaulting on a fine. Indigenous prisoners are usually serving on average shorter sentences than non-Indigenous prisoners. Indigenous children and young people are over-represented in all areas of the juvenile justice system, although they are in general less likely to receive diversionary options than non-Indigenous young people (Cunneen, Boyd-Caine et al. 2001).

Recidivism rates are high with 77% Indigenous prisoners having previously served a prison sentence compared to 58% non-Indigenous men and 49% women (Walsh 2004). There is widespread international agreement on five best practice principles to address and remedy the causes of prisoners offending behaviour and successfully reintegrate them into the community. They are:

- The importance of throughcare (a consistent and progressive case management approach to prisoner rehabilitation) which begins when a person is admitted to prison, continues through the period of imprisonment and ends some time after their release when they are able to live independently in the community.
- The need for holistic aftercare services, particularly in the first 30 days after release.
- The need for pre-release transitional programs where prisoners receive information and advice in relation to the key difficulties they will face on release.
- A preference for gradual release such as through parole, home detention, temporary release, and/or release to halfway houses.
- Addressing the special needs of specific groups (Walsh 2004).

The health needs of prisoners (and ex-prisoners) are also of concern, since about 30% of all male prisoners and 50% of female prisoners have a diagnosable mental illness. About 70% of Indigenous prisoners had problems with alcohol prior to their incarceration. Indigenous prisoners also report very high rates of physical health problems (Aboriginal and Torres Strait Islander Social Justice Commissioner 2002, Walsh 2004).

There is evidence that rehabilitation programs for offenders can have a significant impact in reducing rates of re-offending. The Queensland Department of Corrections offers Indigenous-specific programs to prisoners serving sentences of more than 12 months, including ending offending, ending family violence and sex offender programs. However, shortcomings of the generic prison programs have been identified, including that programs are not sufficiently adapted or flexible enough to meet the needs of specific prisoner groups, many programs may be ineffective, and many programs are difficult for prisoners to access (Walsh 2004). Three main principles underlie the most effective programs:

- higher risk offenders benefit the most from programs;

- the contents and targets of programs should be factors which can be demonstrated to be significant causal influences for offending behaviour itself; and
- programs should be designed and delivered in such ways that participants are likely to respond (Howells, Day et al. 1999).

Community based organisations offer alternative approaches to dealing with offenders within the criminal justice system, including court-mandated and court-referred programs. These include anger management, substance abuse, family wellbeing and ending offending programs. Court-mandated programs for Indigenous offenders can work successfully if they are sufficiently connected to indigenous communities and the program development and delivery is supervised by Indigenous people (Cunneen 2002).

Findings from such programs indicate that:

- A structured program should be delivered to groups within an empowering and innovative learning framework that combines cognitive, behavioural and resocialisation approaches. (that is, programs should not focus on models of support or therapy, but on complete behavioural and attitudinal changes in the offender)
- Program topics for Indigenous offenders need to be culturally sensitive, flexible to be undertaken in a range of settings for Indigenous groups, and to be facilitated by Elders;
- Education sessions should be included on the problems of excessive alcohol consumption;

Offering support to children exposed to domestic violence is a crucial component (Cunneen 2002).

Family violence programs

Crime statistics show that violence in Aboriginal communities is a severe problem. The victims of violence are usually women and young people and the perpetrators of violence are usually men. It is alarming that much of the physical violence perpetrated by or on Aboriginal people is attributable to family violence (Cunneen 2002). Indigenous people nationally are more than eight time more likely than non-Indigenous people to be victims of homicide (Mouzos in Cunneen 2002); and Aboriginal women are 10.7 times more likely than non-Aboriginal women to be victims of violent crime (Harding in Cunneen 2002). Aboriginal women are more than 45 times more likely than non-Aboriginal women to be a victim of domestic violence (Blagg 1999).

Aboriginal women reject the feminist analysis which identifies male violence against women as central to the perpetuation of women's oppression (Greenan 2004). They prefer the broader concept of family violence, which incorporates physical, sexual and psychological violence occurring in the family, including aggressive behaviour as diverse as family feuding, elder abuse, child abuse and

child sexual abuse, spousal violence and disruptive and anti-social behaviour by young people (Blagg 1999).

There are three types of causal factors for the high rates of violence. They are:

- Precipitating or impulsive causes include behaviours such as jealousy, payment of debts, and payback;
- Situational factors include issues such as alcohol intoxication, money problems, unemployment, and communication breakdown between partners, sorry business, persons who encourage a perpetrator to act, and conflicting differences between the antagonists; and
- Underlying causes include loss of self esteem, loss of masculinity/identity, loss of self-respect, loss of respect, and loss of responsibility (Memmott at al 2001). These underlying factors are related to the intergenerational impact of the 'founding violence' of colonisation and more recent assimilationist and removal policies, with their legacy of marginalisation, dispossession and cultural genocide. The related break down of kin and 'skin' systems, the loss of customary law and the 'redundancy' of the Aboriginal male role have also been identified as underlying factors. Contemporary contributing factors include entrenched poverty, institutionalised racism and endemic alcohol and drug abuse (Blagg 1999).

Miller (1992) speculates that the high level of both adult and juvenile crime in seven north Queensland communities (including Yarrabah) could be a response to the lack of opportunity for self-determination. When individuals feel their freedom to choose among alternatives is threatened, they experience an aversive state called "psychological reactance" which motivates them to reaffirm their power and exercise control, often in self-destructive ways. The more options people have, the more they perceive themselves to be in control of their lives and the less depressed (and self-harming and aggressive) they are likely to become. Hence, the need to increase Aboriginal perceptions of their own control and self-determination becomes more urgent (Miller 1992).

While accepting that family violence is a crime and that individuals are responsible for their behaviour, Indigenous women have argued that long-term solutions for addressing family violence in their communities need to involve men. They argue that for a broad strategy of family and community healing with a focus on prevention and restorative justice, and recognition of the diversity of contexts in which Indigenous family violence occurs, rather than a standardised punitive response (Atkinson 2002, Huggins 2003) and reject criminalisation as the main strategy to deal with the problem.

Women often need respite from violence for a short time and they speak of the need for men's places where men can be taken to "cool off". Unlike women's shelters, which are seen as a safe haven or refuge for victims of violence, a men's place would function more as a multi-purpose gathering place. Such a place could offer men a sense of belonging and potentially include a 24 hour

counselling service; counselling for male offenders of violence; networking/referral centre; drop-in centre; healing centre; empowerment centre; enterprise centre; behavioural reform/ perpetrators programs, strengthening identity and support centre; intoxicated men's "sleep it off" place; and men's group planning (strategies, programs, action) centre (Reilly 2004 p 7).

Family violence intervention should ensure victim safety at the point of crisis and impose sufficient controls over perpetrators to prevent future violence, including restraining orders that allow for co-habitation, residence at Family Healing Centres rather than prison, and preventive interventions that add value to existing community structures (Atkinson and Atkinson 1999). Programs for men need to be holistic since the violence cannot be isolated and dealt with as an individual's problem, address the wider issues of grief and loss, and to help young men *"alter distorted views of gender roles and acceptable male behaviour*" (Aboriginal and Torres Strait Islander Women's Taskforce on Violence Report in Reilly 2004). Addressing the broader issues of health, housing, education, employment is also part of the solution. Service providers are also clear that there needs to be a family-focused approach with children and young people as a focus of any program and an emphasis on healing processes (Thompson 1999). Programs need to emphasise the right of Indigenous self-determination in developing and implementing these programs (Cunneen 2002).

A recent report on violence in Australian indigenous communities identified 130 anti-violence programs that had been implemented, were being implemented, or were planned for implementation (Menmott et al 2002 in Cunneen 2002). Approaches include situational crime prevention such as night patrols, social crime prevention such as cultural and other programs for "at risk" youth; community based prevention such as law and justice groups; and tertiary crime prevention such as Indigenous courts. Community programs which appear to be particularly effective are based on the following principles:

- a holistic approach which incorporates different strategies;
- involvement of family members and community Elders;
- guided by the principle of self-determination; and
- comprised of culturally appropriate program content and staff (Cunneen 2002).

Community-based anti-violence prevention and early intervention projects include:

- projects aimed at intergenerational issues such as father-son relationships and mentoring of Aboriginal youth by Elder figures;
- projects aimed at supporting young Aboriginal fathers;
- the creation of men's "meeting places";
- establishing domestic and family violence outreach services targeted at men;
- organizing men's healing camps and/or healing journeys; and

- formulating local violence prevention strategies aimed at indigenous youth
- Community focused programs for both male offenders and non-offenders
- Programs which specifically target men who have been convicted of committing offences of violence (some try to change male/community attitudes towards violence and others focus specifically on individuals)(Blagg 1999, Cunneen 2002).

Challenges include the difficulty in working with the current service system which is based on non-Indigenous feminist principles; expectations of being a panacea for all problems in communities; poor resourcing, training and support (Wright 2004).

A synthesis of the extensive research literature about the outcomes of mainstream programs for men who batter found that there are few studies with rigorous methodologies and hence no firm conclusions can yet be made about the effectiveness of perpetrator programs. There was a high attrition rate in most perpetrator programs and an over-reliance on official records of recidivism as the main measure of the success of the program. The review concluded that the best hope for ending violence against women is from primary prevention strategies and not perpetrator programs (Saunders quoted in Waite 2003).

Approaches to offenders of family violence by Indigenous Community Justice Groups include such strategies as:

- removing offenders from the community (to outstations) for “time out”;
- shaming;
- assisting with the reintegration of offenders into their families and community following incarceration;
- dealing with alcohol management issues;
- trauma recovery programs, such as that described above (in the personal development section); and
- other preventive measures such as establishing local networks of criminal justice agencies and contribution to interagency preventive and support activities (Wright 2004).

The process is seen as effective because:

> *“They know it’s a shame thing with our people. Many of our people know they can misuse the white man’s law, but they know they can’t do it amongst their own. They know the Murri law is stronger, it always was and always will be* (Peena Geia, Chairperson for the Palm Island Community Justice Group in Wright 2004).

Programs may specifically address some of the factors that are directly related to offending behaviour. It may not be reasonable to expect programs to address the broad range of complex issues faced by violent Aboriginal offenders, such as unemployment, alcohol misuse, domestic violence, mental health problems,

distress, family break-up, loss, and traumatic and premature mortality (Howells, Day et al. 1999).

Employment strategies

In 1998, Taylor and Hunter calculated that Indigenous incomes would need to increase by $1.6 billion per annum (in 1996 dollars) to achieve income equality with other Australians. This would equate to about $5,800 per year for each Indigenous adult over 15 years (Hunter and Gray 2001).

Low incomes reflect the marginal attachment of many Indigenous people to the labour force (and therefore to Australian society at large). As Noel Pearson asserts, the consequence of obtaining citizenship in 1967 was: "*We got the right to equal pay but on those terms we were no longer able to find employment*". The government's response of providing unemployment payments, (originally intended as a short-term safety net for a minority of Australians) have become the main form of sustenance in Aboriginal communities (Pearson 2002). Thirty years, or two generations, after citizenship, just over 80 per cent of Indigenous adults depend on some form of government support to prop up their presence in the labour force or to sustain them outside of it (Taylor and Hunter 1998). Structural reasons for people requiring welfare support include poor health, high arrest rates, family responsibilities, lack of local job opportunities and lack of qualifications and skills (Australian Bureau of Statistics and Centre for Aboriginal Economic Policy Research 1996).

Welfare payments did materially advantaged extremely poor Indigenous people and resulted in an increase in financial independence among many females (Hunter and Gray 2001). But the availability of welfare payments, unlimited amounts of leisure time, alcohol and other drugs and a generally permissive alcohol and drug culture in mainstream Australian society have combined to create an 'alcohol epidemic' (Pearson 2000). These have resulted in a mentality that government has the solutions and it's someone else's responsibility.

In place of this passive welfare paradigm, Pearson puts forward four components towards developing a real economy for Aboriginal communities on Cape York. These are: access to the enjoyment of traditional subsistence resources; changing the nature of welfare programs to reciprocity programs; developing communities economies; and engaging in the real market economy (Pearson, 2000). Other options for economic development include creating a mix of initiatives related to the community's competitive advantages including links to existing employment opportunities in mainstream organisations, and developing business opportunities that either provide services Indigenous communities or adopt a cultural niche position within the market (Altman 1998).

There are five key ingredients which have been identified as essential for success in community economic development. These are:

- Belief and expectation
- Collaboration
- Local leadership
- Strategic planning and action; and
- Opportunism (The Municipal Association of Victoria).

Social enterprise initiatives

Instead of funding health programs which can be intrusive into Aboriginal family life, social enterprise solutions can be used as an empowering strategies to address particular health related issues. Social enterprises, or sustainable business enterprises which have a social purpose, have been proposed as potential solutions to upstream health issues as well as having flow-on employment and economic impacts for the community.

At a community level, social entrepreneurs can give back skills, resources and expertise into the hands of people so they can act to solve their own problems and pursue their own passions. It is about investments in initiative, not incapacity (Botsman 2000). Social entrepreneurs use the techniques of business to tackle social problems; they add value to neglected community resources (Sanderson 2000). They are the equivalent of true business entrepreneurs but they operate in the social, not-for-profit sector building something from nothing and seeking innovative solutions to social problems. Their aim is to build ‘social capital’ and ‘social profit’ to improve the quality of life in some of the most ‘difficult’ and ‘excluded’ communities (CAN 2004).

Examples of social enterprises targeted at addressing the upstream drivers of health include:

- A community swimming pool which offers swimming lessons, aquaerobics and a tuck shop only selling nutritious food can be effective interventions to address nutrition, physical recreation and substance abuse (and hence obesity, cardiovascular disease, diabetes, hypertension etc);
- A market garden producing fresh fruit and vegetables at an affordable price, or a café/ takeaway store that only offered healthy food could also impact on nutrition and hence obesity, cardiovascular disease or diabetes;
- A low cost house cleaning service could impact on housing conditions and sanitation and hence health issues such as scabies, skin conditions, communicable diseases and gastrointestinal diseases; and
- A fitness centre that offered weight training equipment and aerobics classes could impact on physical recreation or substance abuse and

Advocacy to influence the broader community and societal issues

Men's groups do not have the power or resources to try to influence the multiplicity of social determinants of Indigenous men's health alone. Despite the appalling health statistics for Indigenous men, severe resource constraints condemn most Indigenous men's groups to remain in a formative stage. Reilly argues that the one factor, above all others, that remains a hindrance to the establishment of men's centres and projects, is that of inequitable funding opportunities. Men's groups are constantly frustrated at the process of locating and applying for limited funding opportunities, and lack of funding severely limits their capacity to restore resilience within their community. Reilly calls for consultation and collaboration with Indigenous men's groups by government agencies such as the Indigenous Coordinating Centres to ensure that funding opportunities are equitable and the significance of men's groups is recognized and their continuation supported (Reilly 2005 p 5). Given resource constraints, it is also critical that men's groups are realistic about what strategies they can take on, both in working directly with individual men and their families; and in broader community issues for which they can work with other organizations to advocate for change (McCalman, Tsey et al 2006, 2006a).

There is general agreement in the literature that Indigenous self-determination is critical and that the role of government agencies should be to enable a community response as opposed to directing or dictating what the response should be (Thompson 1999). Men's Groups can advocate to influence government or community-level policies which affect them. This work requires a vision of what is possible and persistent lobbying to achieve long term change.

Pearson, for example, states that the greatest lever for advancing Indigenous communities may be to examine and improve the way governments pursue welfare, education and economic development. Estimates suggest that governments are the source of 90% of all income and services to Indigenous people in Cape York, and in many communities, Indigenous Australians continue to have very limited economic options. Community activities have been colonised by government grants, and this has displaced community initiative and voluntary contribution. Hence, Pearson claims, there needs to be a retreat of government involvement (Pearson 2002).

In remote communities in the Northern Territory, Beadman recommends that the focus of programs to improve the situation of Aboriginal youth and children should focus on:

- reducing welfare dependence,
- encouraging educational participation, employment and private business development,

- restricting the availability of alcohol and inhalants, and
- enabling Aboriginal customary law to play a stronger role (Beadman 2004).

Some services are controlled by government departments, and the role of community-based Indigenous men's groups is limited to that of advocacy to improve access to services or to providing pre-or post-service additions. In the Corrections system, for example, high rates of Indigenous reoffending, and short length of sentences imply that current measures to promote community safety are not proving successful and that more effort needs to be given to ensuring that offenders who enter the prison system are "corrected" by the time they exit it (Walsh 2004).

Finally, Indigenous men's groups may need to advocate on their own behalf, for example, by attempting to influence current policies that provide ad hoc and one-off funding and hence make it hard for men's group to achieve continuity.

Conclusion

This literature review provides evidence that Aboriginal and Torres Strait Islander men have been displaced and are still subjected to abuse, marginalisation and racism. Structural issues such as educational and employment opportunities determine men's ability to be sober and well, and many men do not have the confidence, opportunity or facilities available to help them improve their health status or positions within their family or community (Adams 2001).

Initiatives by Indigenous men to address their situation include discrete men's clinics; men's programs within Aboriginal Health Services; men's business camps; sobriety groups; sports initiatives; parenting projects; and men's support groups. Commonwealth, States and Territories are developing policies and strategies for both mainstream and Indigenous male health (WPATSIMHWBRC 2003). However, there has been little published research about how Aboriginal men care for their health, few Indigenous men's health initiatives have been rigorously evaluated, and there are no dedicated government funding sources for Indigenous men's health initiatives.

Indigenous men's groups aim towards the Indigenous view of health, defined as "*not just the physical wellbeing of the individual but the social, emotional and cultural wellbeing of the whole community. This is the whole-of-life view and it also includes the cyclical concept of life-death-life*" (National Aboriginal Health Strategy Working Party 1989). It is a holistic concept of assisting people in their everyday life and living and at a personal level, includes spiritual, sensual, sexual and emotional aspects. At a broader level, issues such as self-determination, control over the physical environment, community affiliation, and social and criminal justice can all be encompassed within the concept.

Within Western theoretical frameworks, Indigenous men's group strategies can be seen as primary health care, health promotion, and/or empowerment initiatives. Self determination and empowerment are central concepts to raising self-esteem, quality of life, health status and spiritual well being (Briscoe 1999) and some men's groups have articulated explicit empowerment programs (Tsey, Patterson et al. 2002; Tsey, Patterson et al. 2003). Evidence from the health promotion literature is that multi-strategic programs that encompass advocacy for changes to the broader social determinants, community development, developing personal capacity and improving the orientation of health services are likely to be more effective (though more difficult to evaluate) than single-strategy programs. However, men's groups are likely to be under-resourced to address such a wide range of health and social issues. It is important, in the short term, that issues are prioritised and dealt with strategically at a local level to ensure that interventions are not set up to fail. If such efforts are to be sustainable, it is also critical that government agencies recognize and resource the efforts of Indigenous men's groups.

Indigenous men's groups do not have a conscious agenda of engaging in gender politics. Connell argues to fight for justice in gender relations often means tackling the issues that inevitably divide men such as family violence, homophobia, affirmative action for women, sexual harassment and fathers taking greater responsibility for the care of young children. Paradoxically, in mainstream gender politics, attempts by men to develop a "men's movement" have not addressed sexism but have been subverted towards being "positive" about men and "masculinity therapy" (Connell 2000). For Indigenous men's groups, these issues become even more complex and entangled. Indigenous men are disadvantaged in a primarily white Australian society, and (because of historical processes) suffer some disadvantages compared to Indigenous women (for example poorer health and educational achievements and higher incarceration rates) (WPATSIMHWBRC 2003). However, in general, Indigenous men maintain power both within personal and family relationships and publicly within communities.

In some cases, the work of Indigenous men's groups can be seen to support Connell's suggested strategy of detaching men from the patriarchy in small numbers at a time. Examples of this are men's group's work in preventing men's violence and its consequences; showing increasing willingness to do housework; and supporting fathers who take the primary responsibility for the care of their children (while their partner's work or study) (McCalman et al 2006, 2006a, Tsey et al 2005). At times, however, men's groups tend to focus on the disadvantages they experience in comparison with women. These include men's group dissatisfaction that women's services receive more funding, health services tend to be dominated by women, women are advantaged in family law, and that women may not value and appreciate men (a continuation of their historical experience of disempowerment) (Tsey 2005, McCalman 2006, 2006a). Misuse of

power in one of the few spheres available to them (their personal relationships) can result in the abuse of women and children (Scott 1992).

The literature provides evidence that programs designed with the objective of enabling Indigenous people to take charge of their own lives have enormous implications for both improved health and crime prevention (Hazlehurst 1997, Tsey et al 2002). Programs can foster the development of a range of coping and problem solving skills for individuals, communities and organisations. Techniques include trauma recovery treatments, problem analysis, self-healing support groups, crisis intervention, conflict resolution, teamwork building, action planning and extensive professional development in service delivery. These programs have resulted in evidence of enhanced self worth, resilience, ability to reflect on the root causes of problems, problem-solving ability, as well a greater belief and an enhanced sense of hope that their situation can change. Evidence is also emerging of a ripple effect of increasing harmony and capacity to address issues within the wider community, e.g. poor school attendance rates, critical housing shortage and the creation of work opportunities for men (Tsey, Patterson et al. 2002, Tsey et al 2004).

There has been a consistent (but unheeded) call for the development of “men’s places” within Aboriginal communities. Both men and women have advocated for the provision of men’s places where men can be taken to “cool off” after incidents of violence, and men have identified a need for special places and facilities in their communities where they are able to discuss and address their own health issues. Ideas about these places range from facilities for special clinical services, through special places for discussions and education, to places and facilities where males pursue their health and other interests such as recreation, training and work. The provision of men’s places could act as both a symbolic acknowledgment of men’s “place” or “role” as well as a practical aid to Indigenous men’s empowerment.

At a broader community level, there is a strong call for advocacy to address the underlying historical, social and economic factors, although there are divergent views in the literature about the best place to start. Pearson and Hazlehurst, for example, state that *“without doubt alcohol has become the primary cause of family and community disruption in communities*” (Hazlehurst 1997). Homel et al speculate that the best point of intervention may not be the alcohol use but the aspects of dependence (such as lack of meaningful employment) that are most salient for a given individual (Homel, Lincoln et al. 1999). Adams found that the only “strategy of hope” used by Aboriginal men in caring for their health was a return to country/culture. The men felt that to assist in caring for their health, they needed to go back to their roots and capture the culture they had lost (Adams 2001). Hazlehurst argues that it is doubtful whether significant improvement of the lot of Indigenous Australians will be achieved without real commitment to self-determination at the grass roots and regional levels. She cites that internationally when Indigenous communities have undertaken programs for socio-cultural and

spiritual recovery, over a five to fifteen year period, significant economic recovery has followed (Hazlehurst 1997).

No matter how difficult and oppressive are the history and social circumstances of a particular group, such history should constitute sources of strength and inspiration for change, rather than disablement (Pearson, 2000). There are many things that Indigenous men can do to reclaim their rightful place in society and take responsibility for their actions. Programs that assist men to cope and to take charge of their own lives can go hand in hand with advocating for the issues that are related to their broader oppression.

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