

MANAGEMENT OF CHILDREN'S HEALTH IN THE AUSTRALIAN COMMUNITY

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ABSTRACT

Health risks for Australian youth are discussed in order to make suggestions for their control. Health statistics are examined and a historical description of key developments in Australian family and indigenous policy is provided. While the physical health of youth has improved, there is growing concern about their mental health. This problem can be understood partly as a result of past treatment of deviation from the expected conduct norms of the dominant community, and partly as the consequence of comparative deprivation. Services should be broadly and flexibly coordinated on a regional and community basis to promote health, education and development, including prevention of child abuse and neglect. Key stakeholders should work in partnerships with government and non-government service providers, to deliver health and related services, using a quality management approach to meeting community needs with regionally pooled funding. Self-governance based on relevant international conventions is vital to the process.

INTRODUCTION

HEALTH OF AUSTRALIAN YOUTH

Health is relative. Approximately 600 million of the world's two billion children under eighteen live in absolute poverty. In the poorest countries, children under fifteen are 40% of the population. Poverty is therefore disproportionately absorbed by children (1). Of the fourteen million children under the age of fifteen who had lost their parents to AIDS by 2001, around 90% were in sub-Saharan Africa (2). In 2002, a meeting of the World Summit on Sustainable Development pointed out that one in five children in the poorest parts of the world, will not live beyond their fifth birthday because of environment related diseases. It adopted the goal of reducing this mortality rate by two thirds, by 2015, through addressing household water quality and availability, hygiene and sanitation, air pollution, disease vectors, and injuries.

In Australia, despite community concern about childhood obesity, statistics suggest the physical health of children is excellent. However, mental health should now be a major focus (3, 4, 5). Most Australian women have access to effective fertility control. The birth rate has fallen to 1.7. Despite substantial continuous decline, drowning and motor vehicle accidents remain

the leading causes of death for children under fourteen. Injury, including poisoning, is the third most common reason for hospitalisation, after respiratory and perinatal conditions. Asthma is a leading contributor to childhood illness. Some states require all children to be immunised before commencing school. This prevents diphtheria, tetanus, whooping cough, poliomyelitis, measles, mumps and rubella. The dental health of children is excellent, due to fluoride in the water.

Mortality rates for those aged 14 to 24 are lower than for all age groups, except younger children. Death has been declining, mainly due to reduction in motor vehicle related deaths. Teenage fertility fell sharply between 1971 and 1997, and there have been reductions in new HIV diagnoses. However, mental health disorders, including drug dependence, are a major concern. Two thirds of teenage deaths are attributed to injury. Alcohol dependence and motor vehicle accidents are the greatest problems. Over the period 1979-98, the suicide rate rose by 40%. The death rate from drug dependence among young people in 1998, was almost 5 times the 1979 rate. There are more than three male deaths for every female death and higher male death rates for accidents and suicide, account for most of the difference. On the other hand, rates of depressive disorders are three times higher for young females, and the female hospitalisation rate for attempted suicide is greater for females at all ages, despite the much higher suicide rate for males. The 20% of males in the lowest socio-economic group are 1.7 times more likely to die and 1.4 times more likely to be hospitalised, than the 20% of males in the highest socio-economic group. Socio-economic differences in death and hospitalisation are less pronounced for females.

The relationship between poverty, unemployment and poor health is clear. According to the Australian Institute of Health and Welfare, the risk factors for poor health, particularly in the pre-school years, include difficult temperament, harsh parenting, abuse or neglect; parental mental illness or substance abuse; family conflict, low socio-economic status, and poor links with the community. Social and economic disadvantages such as poor education, unemployment and social issues such as lack of connectedness, have also been shown to have negative effects on the health of youth. However, the profile of health risks in Australia must also be understood in the historical context of the changing expectations of the dominant community. For example, in the 1960s, only white males were allowed to drink in public bars. Acceptance of their heavy alcohol consumption meant its causes and effects were unlikely to be conceptualised as health problems. On the other hand, levels of motor accident death declined sharply, when heavy penalties for drink driving were eventually introduced (6).

COMPARATIVE HEALTH OF INDIGENOUS AUSTRALIANS

In 1998, the first national health promotion goals for cancer, cardiovascular disease, injury and mental health were established in Australia. A national programme aimed at improving

Aboriginal health, was set up. Fostering participation of communities and individuals in decision making at all levels of health service, planning and delivery is also a major national goal (7). In 2001, 410,003 people or 2.2% of the Australian population reported being of Aboriginal and/or Torres Strait Islander origin, up 16% since the 1996 Census (8). About one in four indigenous people live outside urban areas, compared with one in seven other Australians (9). The life expectancy of an indigenous man is 56 years and 63 years for a woman, compared respectively with 76 and 82 in the total population. Indigenous people appear to be about 70% more likely to be disabled or handicapped, than the population as a whole. Lack of essential services, including housing, clean water, electricity, sanitation, health care and education, are factors which combine with unemployment, poor nutrition and drug abuse to explain comparatively poor health.

Improvements in indigenous life expectancy over the past two decades have primarily resulted from reductions in infant mortality and infectious and parasitic diseases. However, indigenous infant mortality rates continue to be more than three times the rate for all Australians in some areas. The 1986 Australian census showed that in the 15-19 years age group, indigenous fertility was almost five times that of non-indigenous people and twice as high for the 20-24 age group. Although indigenous fertility rates have halved in the last decade, in 2001, more than 20% of indigenous births were to women aged less than twenty, compared with 4.2% of those to non-indigenous women. Currently, forty percent of Aboriginal and Torres Strait Islander people are under the age of fifteen. The indigenous advocates Dodson and Jonas respectively note that the age structure in indigenous communities is typical of an underdeveloped country, and that this has enormous consequences (10).

Australian domestic violence research shows a link between alcohol and violence. It also suggests the presence of dependent children in a relationship, increases the likelihood of violence continuing (11). Men are more than twice as likely as women to have substance use disorders and 22% of males aged 18-24 appear affected (12). Alcohol disorders are about three times as common as other drug disorders. Women are more likely than men to experience anxiety disorders, and 11% of young women aged 18-24 report mood disorders. This is more than three times the rate for men of this age. Unemployed people generally have a high rate of substance use and anxiety disorders. Death rates for Aboriginal and Torres Strait Islander youth are almost three times higher for males and twice as high for females as for their non-indigenous counterparts. In 1996-97, almost half of all women admitted to hospital for reported domestic violence were indigenous. Twenty percent of victims and 22% of offenders in intimate partner murders were indigenous. Aboriginal and Torres Strait Islander children make up 28% of all children in the Australian care and protection system.

HISTORICAL CONTEXT OF AUSTRALIAN FAMILY POLICY

The current situation of Australian youth must be understood in historical context. During the 1960s, the advent of an effective contraceptive pill coincided with the general trend towards greater levels of Australian female participation in education and work. In 1972, the Whitlam Labor government introduced a wide range of social policy initiatives primarily as a result of growing community demand for the equal treatment of women, migrants and Aborigines. (indigenous people did not get the vote until 1967). Equal pay cases were initiated. Pearson points out that before this, many Aborigines had a low-paid but vital place in the Northern Australian cattle industry. Later there was increasing dependence on welfare handouts (13).

In 1975, no-fault divorce legislation was introduced. A supporting mother's benefit (retitled the supporting parent's benefit in 1977, and the sole parent pension in 1989) was established, making it possible for a woman to care for a child outside marriage. Prior to this, 'illegitimacy' was a source of great shame. In the general community, an unmarried pregnant woman was expected to marry immediately, or hide and have the baby adopted at birth. Nobody spoke about it (14). In 1972, safe abortions became available after a NSW court found that abortion was legal if a qualified doctor said it was necessary to preserve the woman's mental or physical health. The Medibank system of taxpayer funded universal health care provision, was first introduced in 1973, but dismantled when the Labor government lost office. Labor reintroduced a similar Medicare system in 1984. It performs comparatively well (15). In 1988, a Commonwealth child support scheme was introduced which aims to ensure that parents not living with their children contribute to their upkeep. The Family Law Act was amended to ensure that the courts ordered more adequate levels of maintenance. A child support agency was established to enforce regular and timely child support payments through the taxation system.

The Commonwealth Child Care Act was passed by the Liberal coalition government on the eve of the 1972 election, which brought the Labor government to power. The latter greatly increased funds available for child care (16). It reversed the previous policy by primarily funding long day care centres suitable for use by women in the paid work force. Earlier, the lion's share of funding had gone to sessional pre-schools, through a submission-based funding model. (Housewives from comparatively privileged backgrounds usually made submissions most effectively). Economic support was increased for family day care schemes, where women who are looking after their own pre-school children at home, take on the care of extra children for a fee, with back-up support from local councils.

Other childrens' services may be grouped under substitute care or child protection. The latter services are designed to combat child abuse and neglect. Their origin is comparatively

recent. State welfare departments and other church or welfare organisations have played a role in substitute care and adoption, since the earliest days of white colonisation, whenever children were abandoned or taken from parents. However, the first article on abused children appeared in the Australian medical literature only in 1966. This was path-breaking public evidence, that parents and the community were failing to care for children adequately. Later, the Commonwealth Labor government established the Royal Commission on Human Relationships, which addressed formerly taboo topics such as domestic violence, rape, child abuse, and sexuality. This led to government support for refuges and counselling for women and young people. Formerly, the church and charitable groups had been the sole service providers.

Requirements for medical practitioners to report physical and sexual abuse were introduced in NSW in 1977. Most States have introduced systems for compulsory reporting. Family court staff are required to report all suspected cases under the Family Law Act. Under the NSW Children (Care and Protection) Act of 1987, teaching staff are also required to report suspected cases of abuse. Specialist sexual assault services were set up. Members of the community may also report suspected child abuse to the Department of Community Services (17).

These historical changes contributed to the fact that today many people never marry and around 70% of marriages are preceded by cohabitation. Divorce, single parenthood and blended families are common. A peak of 9798 adoptions occurred in 1971-72, but this had dropped to just over 500 by 2000/01, due almost totally, to decline in local adoptions. Just over half of all adoptions in 2001, were inter-country adoptions. Of Australia's 4.6 million children under eighteen, 1.1 million live with only one of their natural parents, usually because of marriage or a relationship breakdown. Around 88% of children with a parent living elsewhere live with their mother, and 42% of one-parent or step and blended families receive cash child support from the other parent (18).

The stated aim of contemporary family policy is to provide parents with a choice about how to combine paid work with responsibility for care of children. Women are entitled to a year of unpaid maternity leave, and some workers have paid maternity leave. A government funded requirement for twelve weeks paid maternity leave, is now being debated. Currently, day care centres with educational programmes for children under school age are run by government and the non-government sectors, with government subsidy. Pre-schools provide educational programmes and operate on a sessional basis. Local councils usually regulate family day care and provide back-up support to carers. Outside school hours programmes provide for primary schoolers. Occasional care services for preschool children exist, as well as playgroups which meet under parental or carer

supervision. Mobile services for child care and playgroups may provide toy and book libraries as well as parental support to families in rural and remote areas. A regional planning approach rather than a submissions model of funding is necessary, if services are to meet the needs of the comparatively large populations of children in more disadvantaged communities.

HISTORICAL SITUATION OF INDIGENOUS WOMEN AND CHILDREN

The situation of indigenous children has been different from the norm. Through 'protection' acts at the end of the 19th century, state governments could declare them wards of the state and control every aspect of their lives. Manne writes that in 1899 the Chief Protector of Aborigines in Western Australia produced the following typical report:

“The intercourse between the races is leading to a considerable increase of half-castes. Many of them find their way into the missions, but a far greater number are probably reared in native camps, without any sort of education, except a vicious one. Each half-caste so brought up is a menace to the moral safety of the community” (19).

The aim was to transfer 'half-caste' children from Aboriginal camps to Christian missions. The preferred minimum age of removal was six. Many in the white community favoured state-run institutions over Christian missions for separated 'half-caste' children. The missionaries allowed 'half-castes' to marry 'full-bloods'. The government view was that eventually traditional Aboriginal society would die out, and everyone should become white through intermarriage. Removed 'half-caste' children were educated and prepared for work in European society, mainly as manual labourers if they were boys, and as cheap domestic servants, (for which there was insatiable demand) if they were girls. The increasing application of assimilationist policies from the 1940s to the 1960s saw greater numbers of indigenous children removed from their families for alleged neglect, poor school attendance or medical treatment. In 1997, the Human Rights and Equal Opportunity Commission found that between one in ten and one in three indigenous people, had been forcibly removed from their families during the period 1910 to 1970 (20). These people are popularly known as 'the Stolen Generations'.

In the historical context of herding formerly nomadic people onto reserves and taking their children, one can clearly see why contemporary indigenous people feel so strongly about their right to manage their own affairs. Horrific as this practice was, the forced mass removal of indigenous children must be understood in the context that any unmarried pregnant woman was a social outcast who would be pressed to marry, or relinquish the child. On the other hand, social scrutiny of any apparently harmful relations inside marriage was avoided.

THE CONVENTION ON THE RIGHTS OF THE CHILD

In 1989, the United Nations (UN) General Assembly unanimously endorsed the Convention on the Rights of the Child (CROC) and Australia ratified it in 1990. The Convention affirms the rights of children to special protection and to opportunities and facilities for healthy, normal development. It extends the concept of human rights to a healthy standard of living, without discrimination on the basis of race, colour, sex, religion, political, ethnic, social or other status. Article Three states the best interests of children shall be the primary consideration in matters which centrally affect them. Article Twelve states that children shall have the right to be heard and to express their own views, which shall be given due weight, in accordance with their age and maturity. The Australian term 'Stolen Generations' tends, on the other hand, to suggest that children are property.

In 1991, the National Child Protection Council was established to gain a national approach to child abuse prevention. It consists of a Commonwealth government representative, one from each State/Territory and five expert community members. It provides general and cross-portfolio advice to the government through Ministers for Community Services. Each State and Territory has its own branch of the National Child Protection Agency. Primary prevention programmes target the whole community. Secondary prevention targets populations deemed to be at risk. Tertiary prevention, refers to interventions to help those who have already been abused.

In 1994, NSW Health committed recurrent funding to each of the seventeen area health service management structures, for the enhancement of physical abuse, emotional abuse and neglect services. Coordinators were appointed to assist development of service models in regional areas, and to implement strategies to improve the coordination, quality and scope of services. In 1995, a National Child and Youth Health Policy was established to improve health, enable equity of access to comprehensive services and to improve their quality. Across Australia in 1993/94, State and Territory welfare departments received close to 75,000 reports of child abuse and neglect - an increase of 25% over the previous year. The numbers kept on rising. Most reports come from friends and neighbours, followed by parents, guardians, school personnel and police.

Investigations may be carried out by the Department of Community Services, or another agency, such as a hospital, police, or both. The responsible officer determines an assessment outcome. Substantiated cases are assigned to one of four categories - physical, emotional, sexual abuse, or neglect. A child who is the subject of a substantiated case of abuse or neglect, may be placed under a 'care and protection order', or placed in substitute care, or both (21). In 1994 there were 12,750 Australian children under care and protection orders. Children may be placed in foster care, with another parent or relative, in residential care or

in a corrective establishment. The Department of Community Services currently provides a large proportion of residential care and it is also provided by the voluntary sector. Kinship care, through child placement with relatives or other family members accounts for around 40% of total placements. Standards have been developed for substitute care services, and a code of conduct for group homes and refuges has been written. However, the Department is currently a planner, funder, monitor, purchaser, broker, provider, and programme and policy developer in regard to children's care needs (22). Its regulatory and service management functions require clearer definition to ensure accountability. Many other groups and individuals should also be made more clearly accountable for ensuring delivery of caring, reliable support which meets the needs of children and families.

THE CONTEMPORARY CHILD HEALTH DIRECTION

More highly educated women are also more likely to do paid work and to have fewer children. This increases social inequality. Employment and apprenticeship in manufacturing has declined and the proportion of Australians on unemployment, disability or supporting parent pensions has grown. Currently, around 2.6 million Australians are on income support payments - one in five people of workforce age, compared with one in seven ten years earlier. Around 900,000 Australian children are in households with no adult in paid work and of these 500,000 are in lone parent families (23). Centrelink offices run by the Commonwealth Department of Social Security provide pensions, and non-government sector organisations across Australia have been contracted to provide Job Network offices to assist job placement. The Commonwealth has now introduced 'mutual obligation' policy. There is general agreement that the community should support and assist those who cannot support themselves, and that individuals should contribute what they can to the community. There is debate about how this ideal should be delivered.

In 2000, the NSW Health Council initiated area health service plans containing population profiles, including socio-economic status and information about needs of the aged (24). A coordinated planning approach to meet the needs of children is required. The concept of community based rehabilitation (CBR) promoted by the International Labour Organisation, the United National Educational Scientific and Cultural Organization and the WHO states that 'community' may mean a group of people with common interests who interact with each other on a regular basis. Alternatively, it may mean a geographical, social or government administrative unit (25). This provides a micro and a macro perspective to assist planning and programme management, which can also be broadly based around the area health service, local government or other appropriate regional boundaries relevant for achieving identified community goals.

Community partnerships with government and non-government organisations are needed. The regional framework should coordinate local, state government and non-government health, child protection, education and recreation related activities with broader community development aims. Local governments have already made agreements with Aboriginal communities in NSW about infrastructure needs and maintenance, as well as the provision of other council services (26). Affordable, flexible and diverse children's services need to be coordinated with this and other relevant health plans (27, 28) to provide a comprehensive network of community support, especially for families with special needs. Three tiers of government are involved in funding, regulating and providing child care services. Since 1994, a condition of continued funding has been to register services with the National Childcare Accreditation Council, and provide self-assessment of the quality of care, measured by 52 criteria. This assessment is validated by external peer review appointed by the Council. Services are expected to give preference to children in families where both parents (or a sole parent) is in the labour force or studying; children who have a disability or whose parents have a disability; children at risk of abuse or neglect; children of parents at home with more than one child under school age; and sole parents.

After some damning inquiries, the NSW Premier has committed an extra \$1 billion over five years, to address child abuse and neglect (29). A general requirement for out of home care plans, developed in consultation with the child and relevant others should be implemented for every child at risk, whether the care is in family, group or institutional settings. Funds may be necessary for one-on-one care for the most troubled. The NSW departments of health and school education recently collaborated with the Catholic Education Commission and the Association of Independent Schools on a manual of steps, for schools to plan their interface with homes and communities (30). Technical and further education institutions and universities should provide planning, mentoring, research, education, monitoring and assessment services related to community projects. For example, Green and Brown describe a project which has four strands. The first aims to give young people something to do; the second aims to increase communication between the generations; the third covers all aspects of living arrangements; the fourth seeks harm minimisation (31).

Kendig and Duckett propose that all Commonwealth and State funds for aged care services, be pooled into a single regionally managed fund (32). A major advantage would be that care could be better tailored to local circumstances. They recommend housing and aged care be funded separately, with streams for accommodation on one hand, and for living costs and care needs on the other. Care provision based on identified personal needs should apply the current resident classification system for the elderly, irrespective of whether services are provided in residential care, or the home. Community managed implementation of national standards should assist development of a more coordinated, data driven, consultative, flexible

and effective approach to improving services for the elderly. A similarly coordinated approach to provision of child and family support, appears appropriate.

COORDINATED COMMUNITY MANAGEMENT

Pearson recently claimed that some indigenous communities are being destroyed by 'passive welfare' and a related substance abuse epidemic. He argued there should be no more unconditional support in indigenous communities for substance abusers, enforcement of social order and mandatory treatment. The Aboriginal and Torres Strait Islander Commission (ATSIC) is the primary Commonwealth authority responsible for assisting self management by Aboriginal communities and providing assistance to meet related community development aims. It oversees an Australian network of thirty-five elected Regional Councils. In 2002, Geoff Clark, Chairman of ATSIC, pointed out that, of an overall figure of \$2.3 billion of Commonwealth funding for services to Aborigines and Torres Strait Islanders, the ATSIC budget was \$1.1 billion.

Two large programmes account for more than half of the Commission's expenditure. They are the Community Development Employment Projects (CDEP) programme and the Community Housing and Infrastructure Programme (CHIP). The former outlaid \$450 million in 2001-02 and the latter \$240 million. Additional ATSIC expenditure of between \$30 million and \$60 million per annum, focuses on native title and land rights, legal aid related prevention and diversion, commercial development and a self-funding home loans scheme. Smaller ATSIC programmes support indigenous broadcasting and other media, language maintenance, arts, crafts and other cultural activities, heritage and environmental protection, sport, recreation and family reunion services for the 'Stolen Generations'. Budget expenditure is not entirely at the discretion of elected representatives. The Federal Government asks the Commission to guarantee minimum levels of expenditure on about two thirds of its budget. A recent Commonwealth review of ATSIC aims to improve transparency and management accountability through clearer separation of policy and administrative responsibilities.

The apparent success of CDEP, which is more than 'work for the dole' suggests the programme requires expansion and coordination with programmes such as the NSW Aboriginal Family Health Strategy and other relevant indigenous and non-indigenous programmes. Indigenous participants voluntarily forego entitlements to income support payments in return for increased training and work opportunities. CDEPs are used as a stepping stone into more meaningful employment. The first CDEP started as a pilot project in 1976, to provide work opportunities for indigenous people in remote areas. More than 36,000 people currently work in urban, rural and remote locations on a diverse range of projects and enterprises such as freight transport, fencing, waste control, horticulture, aquaculture, broadcasting, tourism, education and aged care. Broader coordination between CDEP projects and appropriate theoretical

and practical education and employment is vital for individuals who wish to climb a particular career ladder, as well as provide effective community service.

Plans to support children and families should be established in a community development context. A recent Cape York Justice Study appears to offer an approach for indigenous community development, which has broader relevance. It recommends that each Aboriginal community develop simple action plans. A coordination unit established in the Queensland Premier's Department may help with planning, prioritisation and costing. The report says curbing alcohol and substance abuse, and breaches of the law, especially violent offences, should be priorities. Agencies assisting communities to implement their plans would be accountable to their respective Ministers and would make periodic progress reports to the coordination unit, which should also have the ability to divert funds between agencies. No advisory group or other expedient should be interposed between the coordination unit and the communities.

QUALITY MANAGEMENT

Behrendt comments that indigenous people raise an important question for anyone concerned about Australian democracy (33). Her query is that if policies, institutions and procedures do not work for a small, socioeconomically disadvantaged minority, how good are they? She argues that indigenous experience provides a vital measure of legal norms and institutions. The use of this experience as a measure of the effectiveness of rights protection, will necessitate investigation and understanding of those unique experiences, histories, narratives and identities, bringing them to the centre of discussions over rights and democracy. This is in the general interests of Australian, international and indigenous development.

Local people may have intimate knowledge of the needs of their particular communities, but relevant UN Conventions reflect the agreed values and principles of an ideal international, multicultural and democratic society. The application of these guiding principles at the local level promotes consistent, equitable treatment and more effective comparison of outcomes everywhere. This should serve to promote cultural diversity and individual choice, while reducing any oppressive features which may be related to traditional decision making in any society. In the absence of a universal, multicultural and democratic approach to social regulation, diversity of beliefs and decision making practices may lead to increased social differentiation but also to increased social intolerance, moral confusion and related conflict.

Transparency is necessary for management accountability. Popper stated that all social administration should be conducted as experimentation and combine discovery and implementation in one process (34). Action research, like health promotion, risk management and programme or project management, proceeds in a spiral of steps, composed of a cycle

of consultative planning, action, and fact finding about the results of the action. In this process, people should use an evidence based approach, not slavishly apply received standards regardless of apparent needs in a particular situation. Risk management requirements of State occupational health and safety acts, and those for professional independence are consistent with this. Decision makers should deviate from the relevant approved practice, if the evidence is that another is likely to be better in a specific situation. The deviation from normally expected good practice and its justification should then be recorded. Documentation of the decisions and outcomes of individual judgments should be aggregated and studied. This comparative research leads to increasingly informed evaluation of practice in all settings, to continuously improve outcomes (35).

The Human Rights and Equal Opportunity Commission, ideally has a role in community based service delivery related to implementation of UN Conventions and other standards. The Commission was established in 1986, to administer federal laws on human rights and discrimination. Its main responsibilities relate to public awareness and education, complaints, human rights compliance, policy and legislative development. Among its responsibilities, the Commission oversees implementation of the Convention on the Rights of the Child, the Racial Discrimination Act (1975), the Sex Discrimination Act (1984) and the Disability Discrimination Act (1992).

The UN statement on CBR stresses that improving the capacity and skills for facilitating community involvement is very important and must be closely coordinated to ensure optimum use of scarce resources. Systems should be developed, at the community level and between government and non-government organisations that reach out to each other and also more broadly to employers and other communities. The National Committee on Human Rights Education (Inc.) is an independent association established with the support of government, business and community groups dedicated to promoting and extending human rights education. The Federal Government sees the Committee as the national focal point for the UN Decade of Human Rights Education (1995-2004). The committee requires support from schools, employers, technical and further education colleges and universities.

CONCLUSION

The physical health of Australian youth is excellent but there is growing concern about their mental health. Alcohol dependence and motor vehicle accidents remain leading causes of death and injury. Suicide levels have risen and so has the death rate from drug dependence. The statistics must be understood in historical context. Since the 1970s, Australia has experienced the demise of many traditional expectations about family and working life, including a reduction in suppression of information about deviations from expectations of the dominant church and community. Problems in self-perception, self-acceptance, and relationship

to others can be understood as the logical consequence of comparative childhood deprivation. This is a particular issue for the health of indigenous Australians. Regional services should be broadly coordinated and designed to promote community health, education and development, including the prevention of child abuse and neglect. Community representatives should work in partnerships with government and non-government sectors to deliver health and related services using a regionally pooled funding approach and quality management which aims to meet consultatively identified community needs. Education for community self-governance in the light of the requirements of relevant international conventions is vital to the process.

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