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Reducing child abuse and neglect - a public health approach

*Dr Lance Emerson, CEO,
Australian Research Alliance for Children & Youth (ARACY)*

Our current systems for protecting children are not geared towards prevention; they are geared almost exclusively toward treatment – waiting for things to go wrong.

The great gains we've made in public health over the past decade weren't achieved through waiting for things to go wrong. They were made through taking a whole of population approach, a focus on prevention, understanding underlying causes, and implementing sustainable systems to address these causes and identify and act on risk factors as early as possible.

Last year the Australian Research Alliance for Children and Youth (ARACY) released a report 'Inverting the Pyramid' which identified evidence on how to shift from treatment to prevention, from a systems perspective.

The challenge is to bring together the best of knowledge, professional experience and the evidence of 'what works', and to equip those working with children with the tools to untangle complex issues and respond sensitively to the needs of children and families. The aim is to ensure children and families do not progress along the pathways which lead to abuse and neglect, which trigger costly and often ineffective interventions.

But how can such a shift to prevention be integrated into day-to-day practice? The *Common Approach to Assessment, Referral and Support* project (CAARS) attempts to do just that. This *Common Approach* is designed for use by practitioners such as child care workers, doctors, community health nurses, teachers and school counsellors who come into contact with children and their families on a daily basis. It assists practitioners to sensitively and carefully delve more deeply into difficult issues as well as affirm a child's or family's strengths and protective factors – and come up with an agreed pathway of support that is likely to involve collaborative partnerships among several key players. Such partnerships start with the child and their family, extended family and informal community networks, the practitioner and their organisation, and relevant support services available in the wider community.

This development of this secondary prevention approach was undertaken through a high level taskforce facilitated by ARACY, involving peak professional groups, representatives from every State and Territory, as well as the Federal Government. The key to its development and ultimately to its effective implementation is a shared



Dr Lance Emerson

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Reducing child abuse and neglect - a public health approach

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vision for collaborative action to enhance the safety and wellbeing of all children.

ARACY is currently planning for the next stages in the development and implementation of the *Common Approach* (via formative and ultimately efficacy evaluation), and I encourage all readers of InTouch to check our website at www.aracy.org.au for updates.

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Students win the PHAA Annual Conference Poster Prize

The Aboriginal Health Council of South Australia (AHCSA) won the 2010 PHAA Annual Conference poster prize for their poster titled "Racism is Alive and Kicking in Australia". The AHCSA is the peak body for Aboriginal community controlled health and substance misuse services and Aboriginal Health Advisory Committees in SA. The production of the poster was a collaborative effort involving a partnership between research students studying at the AHCSA and a health promotion student from Flinders University.

The research project underlying the poster was on the topic of racism and was conducted as a part of the *Certificate IV Indigenous Research Capacity Building*. The overall aim of the course is to increase the number of Aboriginal people able to conduct research and evaluation.

The racism project was conducted by our class of 18 Aboriginal Health Workers and Aboriginal research assistants under the guidance of lecturers Merridy Malin, Jerry Moller and Amanda Mitchell. The project found that of the 28 Aboriginal people participating in the research, 90% reported that they had been subjected to racism. The majority of these people stated that their experiences with racism had impacted on their physical, social and emotional health and wellbeing.

The types of experiences people described included being turned away when seeking medical treatment, being ignored repeatedly when waiting to be served in shops, being the recipient of offensive and abusive remarks, being questioned about the authenticity of their Aboriginality and being questioned about the legitimacy of claims of racism. Five of the examples provided are illustrated on our poster.

The participants wanted these stories to reach a broader audience beyond the services, projects and organisations in which they worked. Hence our poster presentation at the PHAA conference.

At the time, Flinders University student Luisa Virgara accepted a placement with AHCSA to work on the production of the poster. Luisa had no experience of poster presentations at conferences and had not used graphics design software before and so was on a steep learning curve. But she brought creative talent, technological acumen, an attention to detail and a passion for helping to work against racism to the task. In response to her conceptualisation of the poster, case studies from the research were selected and suitable props and candidates were found to produce the cameo roles. The people photographed included AHCSA colleagues, and friends Katho, Alicia and Shania Campbell. Anna Virgara volunteered her time and expertise to photograph the vignettes. The photo shoots allowed the topic of racism to be openly discussed, as each photograph represented contemporary experiences of racism and required the models to portray to the viewers of the poster, the feelings, expressions and emotions felt. Despite the seriousness of the topic, all the people involved enjoyed themselves immensely. Then Luisa set to work to produce a poster which would 'catch the eye' while effectively promoting the disturbing messages underlying the stories from our research.

We value the opportunity provided through the PHAA conference and the collaboration between AHCSA and Flinders University to produce a powerful statement in an effort to communicate the existence of racism.



To view the poster visit: <http://www.phaa.net.au/documents/40thAnnualPosterWinner.jpg>

L to r back: Patti Mackay, Loretta Weatherall, Glenys Dodd, Brenda Carter, Belinda Hammond, Margi Sumner, Eunice Aston & Donna Weetra
Front: Neil Coleman, Lincoln Dudley, Alwyn Graham, Rick Hartman & Corey Summers
Missing: Rebecca Kimlin, Michelle Merrick, Amanda Mitchell, Eva Pratt & Rosney Snell

Profiling PHAA Life Members

Life Membership is one of the few privileges that PHAA can award to its members who have given exemplary service to the association throughout the years.

Bob MacLennan

Life Member since 2001

My professional life has been unpredictable with chance being a major factor. In 1952 as a medical student in Brisbane I was balloted as one of three from 45 applicants from Brisbane to spend 10 weeks employed in Papua New Guinea as a Medical Assistant in Goroka in the Eastern Highlands. With the guidance of the sole doctor, I treated highly endemic yaws, scabies and tropical ulcers and assisted at surgery - for example ether anesthesia. As a student I was taught public health and community medicine by Professor Douglas Gordon, ultimately a founder of PHAA.

After graduation and hospital residency, I did the Diploma in Tropical Medicine at the University of Sydney before returning in 1957 to New Guinea as doctor for the hospital in Mount Hagen. I was also Acting District Medical Officer and the only government doctor for the Western Highlands, a region that covered a large area from the Wahgi Valley to the Strickland River. In 1958 I transferred to a newly formed Division of Medical Research in the Public Health Department and in 1959 was sent to Kikori hospital and district in the Gulf of Papua. I was then transferred to Maprik hospital in the Sepik District. Maprik was surrounded by the Northern Abalam whose traditional culture of superb music, dance, painting and sculpture had been enabled to survive by the government administration who defied attempts by most Christian missionaries to destroy it. Further away from government influence, a priest burned ceremonial houses and banned traditional painting.

In 1960-1961 I took unpaid leave for further study to upgrade my clinical skills at the Postgraduate Medical School, London. I passed the examination for Membership of the Royal College of Physicians of London and for 3 months was Visiting Lecturer in Child Health at Makere University Hospital, Uganda, with Professor Dick Jellife, the world leader in childhood nutrition in developing countries.

In January 1962 I was invited by Professor Gerry Shaper to join a survey of blood lipids in Samburu and Rendile nomadic herders of Northern Kenya. Back in Maprik by May 1962 I worked with Professor Frank Schofield who had by then done the first randomised trial demonstrating that immunisation during pregnancy prevented neonatal tetanus which then killed one newborn in 20.

In 1964 to 1966 I completed course work and thesis for a Masters degree in Epidemiology through Tulane University Medical School, New Orleans. I worked on the thesis in Tulane's International Center for Medical Research and Training in Cali, Colombia. I continued studies of tetanus immunisation, immune response to malaria and with an anthropologist, a study of response to illness in Chechua-speaking Native Americans in the



Bob MacLennan



Kandep 1957: Medical Assistant John Tommerup talks about hygiene, mainly latrines, with medical orderly translating.

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Profiling PHAA Life Members Bob MacLennan

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south of Colombia. After 2 years as Assistant Professor I was appointed Associate Professor in Epidemiology in both Tulane University and the Universidad del Valle, Cali.

In 1971 I was appointed as an epidemiologist at WHO's International Agency for Research on Cancer (IARC) in Lyon, France. I initiated studies on the intestinal ecology of bowel cancer in Denmark and Finland in collaboration with colleagues in Copenhagen and Kuopio, Uppsala, Cambridge (*Professor Phil James et al*) and the Bacterial Metabolism Research Unit at Colindale, London. I established a case-control study of lung cancer in Chinese in Singapore and in Thailand I worked with an anthropologist on a survey of the details of smoking and betel chewing in a population near Chiang Mai.

In 1979 I returned to Sydney as Associate Professor in Epidemiology at what was then the Commonwealth Institute of Health, University of Sydney and a year later was directed to develop studies on the health effects of Vietnam service.

In 1982 I was appointed as Senior Principal Research Fellow at the Queensland Institute of Medical Research (QIMR), the first medical research institute in Australia to establish a programme in Epidemiology. Since my retirement in 1996 epidemiology programmes have continued to collaborate widely and grow to include over 100 of QIMR's 700 researchers and support staff. I have also continued studies of oral cancer in PNG and returned many times to document my large collection of 16mm film and Sepik music recordings. One of the latter was selected by Alan Lomax as an example of world music in the 1977 Voyager interstellar spacecraft.

I was appointed Chair of the programme committee for the ANZSERCH-PHA annual conference held in Brisbane in 1983 at the University of Queensland. The programme focused on epidemiology and methods. The important linkage between Epidemiology and Public Health has been recognised for many years and was recently re-established with a joint conference of the Australian Epidemiological Association and PHAA.

AUSTRALIAN-BASED RESEARCH STUDY – EPIDEMIOLOGY OF FSHD

Facioscapulohumeral Dystrophy (FSHD) is a debilitating life-long muscular dystrophy which affects an unknown number of Australians. Recent European data suggests FSHD may be the most common of all dystrophies, however no detailed study has ever considered how widespread the disease is within Australia.

FSHD Global Research Foundation, an Australian based organisation funding medical research into FSHD, is calling for expressions of interests from Epidemiologists interested in undertaking a comprehensive population-based study to examine the prevalence and incidence of FSHD in Australia.

The study will likely entail the interviewing/surveying of neurologists in Australia (the primary group of specialists managing FSHD patients) and potentially members of other specialties also. Several key research parameters, including the prevalence and incidence of FSHD in Australia, should be examined by the study, with all data to be based on Australian information sources.

It is anticipated that the authors publish their findings in a respected Australian medical journal.

Anyone interested should contact research@fshdglobal.org for further details or visit www.fshdglobal.org/callforapplications

Better informed consumers: nutrition labelling of menus in fast food chain stores

*Authors: Tuesday Udell, Anne-Marie Mackintosh, Susan Anderson and Jane Potter
National Heart Foundation of Australia*

In March 2010, the US Government passed legislation requiring chain restaurants with 20 or more outlets to provide nutritional information to consumers at the point-of-purchase. At least three Australian state governments have signalled their interest by calling for nutrition labelling on menus in fast food stores.

Eating out is part of today's Australian lifestyle. Purchasing and eating foods away from home is no longer a special treat. Australians now spend 42 cents in every food dollar eating out of home. The danger when eating out is that portion sizes are larger and in many cases the meals contain more energy, saturated fat and salt than meals prepared at home.

In Australia in 2009, 3.7 billion meals were served by commercial foodservice outlets. Of these meals, 1.6 billion were from fast food outlets, of which 60% were quick service (fast food) restaurant and snack food chain stores. This means that in 2009, 4.5 million Australians visited a fast food outlet every day.

In September 2010 the Heart Foundation published a rapid review of the literature on nutrition labelling at fast food and sit-down restaurants. The report describes the evidence on: consumer attitudes towards nutrition labelling on menus; knowledge about the energy in foods eaten out; use of nutrition labelling on menus; evaluation of label formats; the efficacy of additional nutrition information on menus on food choices; and the efficacy of nutrition labelling on menus on sales.

What were the findings of the report?

Studies indicate that the majority of consumers considerably underestimate energy, total fat, saturated fat and sodium content of unhealthy foods. This was not the case with healthy foods, for which consumers have been shown to either slightly underestimate (or even overestimate) the content of energy, total fat and saturated fat. In addition, many consumers were not aware of the energy they needed to eat each day.

Nutrition information as currently provided on posters, pamphlets or websites was not readily accessed but consumers supported including this information on menu boards. Energy information was noticed more if it was put on menu boards or closer to the point-of-purchase. There was some preference for fat and fibre information to be labelled in addition to energy information.

Measuring the impact of menu labelling is complex. While some studies reported average energy reduction of 15–250 calories (US studies) when menu labelling was provided, other studies reported no impact or mixed findings. The consumer benefits of menu labelling may be greatest among certain population groups, such as women and parents choosing for their children.

The Heart Foundation suggests that nutrition labelling on menus may encourage the fast food restaurant and snack food chains to introduce healthier foods and reformulate existing foods, as happened with the introduction of mandatory labelling on packaged foods.

What is the Heart Foundation asking?

The Heart Foundation is calling on state, territory and federal Governments to:

- legislate and enforce mandatory nutrition labelling on menus and menu boards at point-of-purchase. The minimum standard for labelling should be energy (kJ) and, optimally, labelling should include saturated fat and sodium per serve, with a reference to daily kilojoule intake.



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- fund and run an education campaign to help Australians understand what menu labelling means and how to use it to choose healthier foods.
- monitor and evaluate the menu labelling initiative to determine efficacy in Australia.
- support further research to build evidence for future action.

Specifically the Heart Foundation recommends that the legislation should apply to food service stores (including bakery/café chains, quick service restaurants, and snack food stores) with 20 or more outlets providing standard menu items.

Governments should also support food industry to provide a greater number of menu options that contain more fibre and less energy, saturated and trans fats and sodium. This can be achieved through food and recipe reformulation, and by using healthier ingredients and cooking methods.

The full report and a summary of recommendations to government are available to download on the Heart Foundation website at <http://www.heartfoundation.org.au/sites/HealthyEating/Healthprofessionals/Pages/NutritionLabellingonMenus.aspx>

PHAA 41st Annual Conference

Sustainable Population Health



**Abstract submission site
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Climate and Health Alliance flourishing with PHAA support

Fiona Armstrong, Convenor of the Climate and Health Alliance

The newly established Climate and Health Alliance (CAHA) is gaining strength – with members of the Alliance off to Canberra this month to meet with federal parliamentarians and advocate for urgent action on climate change.

CAHA delegates will join others from the Climate Project and the Southern Cross Climate Coalition to meet with MPs, Senators and backbenchers as well as members of the Opposition and Shadow Cabinet. The delegation will urge the implementation of effective climate policy action in this term of the parliament, including a price on carbon to create a financial disincentive to produce emissions.

The Public Health Association of Australia is a founding member of the Climate and Health Alliance and CEO Michael Moore is a member of its inaugural Executive Committee. Since its establishment at a meeting in Melbourne in August, the Alliance has made several public statements urging the recognition of human health as a priority consideration when it comes to developing climate policy.

With the establishment of the federal committee on climate change, the new parliament represents a fresh opportunity for action on climate change. The establishment of the national Climate and Health Alliance is timely and offers an opportunity for health professionals and other health care stakeholders to emphasise the health effects of climate change and share their expertise regarding the need to consider human health in the development of policies to address global warming and ecological degradation.

The development of a sustainable population strategy in the upcoming parliamentary term is another area in which the Alliance will contribute to policy development by highlighting the health issues associated with population growth.

The Alliance acknowledges that action to reduce the health risks from climate change requires action across a range of policy areas and sectors, and that governments, businesses, civil society, the community, and individuals all share the responsibility for taking action to reduce climate risk.

Together with its members and partners, the Alliance is seeking to raise awareness in the health sector and the broader community that policies to reduce greenhouse gas emissions have the potential to bring important public health benefits.

This includes conveying the message to health care stakeholders and policy makers that action to reduce greenhouse gas emissions can not only reduce the health risks associated with climate change and environmental harm, but can also improve health outcomes, and reduce costs through increases in physical activity, improved air quality, and improved diet.

Far from putting us at risk, there are strong economic, environmental, social and health benefits for the populations of countries that take effective action to reduce emissions.



CLIMATE AND
HEALTH
ALLIANCE

Smoking and mental illness: the way ahead

Rebecca Gordon, Consultancy services manager, RaggAhmed

Recent discussions have raised the role of health professionals in reducing social inequalities and improving social inclusion. In the UK, The Royal College of Physicians released a policy statement, *How doctors can close the gap: Tackling the social determinants of health*, which recommends actions ranging from considering the impact of day-to-day practice on health inequalities to advocating policies and programmes that could benefit the physical and mental health of socially disadvantaged groups while also resulting in reductions in greenhouse gas emissions. This leads to the questions 'What can Australian health professionals do to tackle social determinants?' and 'How can we ensure that health is included in policies and actions to increase social inclusion and reduce inequality?'

People with mental illness often face multiple forms of social disadvantage. They are more likely to be unemployed, more likely to be socially isolated, and more likely to smoke.



Smoking is recognised as both an effect of, and a contributor to, social disadvantage. There is a clear social gradient in smoking among adults in Australia. It is more common among people living in disadvantaged areas, it is more common among Indigenous people, among unemployed people and more common among people with mental illness.

As well as smoking-related illness and early death, the financial cost of smoking leaves less for essentials like accommodation, meals, clothing and healthcare. Not having these essentials further marginalises disadvantaged members of our community.

Efforts to reduce smoking in the general population have not effectively targeted people with mental illness. In some cases people with mental illness have even been encouraged not to quit. This goes against the fact that a large number of people with mental illness want to, and can, quit.

Reducing smoking among this group will improve their quality of life. It will improve their physical health and have a positive impact on their finances. It will contribute to closing the socioeconomic gap in health and to achieving social equity.

Many who care for people with mental illness believe that quitting will exacerbate symptoms or that it's just too hard for someone with mental illness. Smoking has been seen as a way of self-medication, reducing tension and controlling symptoms.

It is now clear that smoking does not ease stress – smokers are more stressed than non-smokers. Smoking does not medicate mental illness – it just reduces the withdrawal symptoms that come with not having a cigarette.

Uncertainty about providing support to quit smoking has led many health professionals to put off addressing the issue. How do we manage smoking cessation in people with mental illness? Will there be problems? Will quitting affect medication levels? Is that a problem if it does?

The way ahead is clear. We need to establish smoking as a problem for people with mental illness, rather than a solution. We need to provide health professionals with the skills, knowledge and confidence to help their patients and clients quit. And we need to empower people with mental illness to demand that they be treated with the same respect as others in society by being encouraged and supported to quit.

Centre for Research and Action in Public Health, The University of Canberra – the first three in a collection of six articles

The Centre for Research and Action in Public Health, The University of Canberra, with support from the ACT Department of Health, aims to provide local and national leadership in improving health promotion and wellbeing research and in disseminating this research to academic, policy and lay communities. Led by Director, Professor Rachel Davey, and Deputy Directory (Research), Associate Professor Helen Berry, the Centre's research focuses on multi-disciplinary approaches in three broad areas: primary and secondary prevention of chronic disease; environmental, cultural and psychosocial determinants of health and wellbeing; and enhancing ways in which new knowledge informs policy, practice and service delivery for improving community health and patient care. The three articles below are the first in a series reporting on research projects being undertaken by staff and students in the Centre. The second set of three articles will appear in the December issue of In-Touch. References are available from the authors.

For further information about the Centre, please visit <http://www.canberra.edu.au/faculties/health/CeRAPH>.

1. Lack of activity destroys the good condition of every human being, while movement and methodical physical exercise save it and preserve it. ~Plato

Professor Rachel Davey

These wise words from Plato are still very relevant to us in the 21st Century. Physical activity must be one of the most undervalued interventions to improve health and possibly the “best buy” in public health as described by Professor Jerry Morris, one of the great figures in public health. The recent ACE-cost-effectiveness of prevention report¹ showed that a package of physical activity interventions including pedometers, GP referral and active transport, would contribute approximately 34% of the population health benefit that could be achieved if everyone increased their physical activity to recommended levels.

There is now a substantive amount of research that highlights the importance of the social, physical and policy environments on the ability or likelihood of individuals participating in physical activity (and in engaging with other healthier lifestyle behaviours). Human behaviour is difficult to change, especially in an environment such as ours that mostly encourages sedentary behaviour. In order to increase population physical activity, efforts need to focus not only on the behaviour choices of each individual but also on wider determinants and factors that influence those choices. Many of the factors influencing health lie in the complex social, economic and physical environments in which people live, and therefore require a more social view of health. The socio-ecological model provides a useful integrative framework for achieving a better understanding of the multiple factors and barriers that impact on health behaviours. This model considers the complex interplay between individual, family, community, environmental and societal factors on health and helps to identify opportunities to promote participation in physical activity by recognising the multiple factors that influence an individual's behaviour. Efforts to change behaviour are more likely to be successful when the multiple levels of influence are addressed at the same time.

I suggest that the field of intervention research in physical activity needs to be based upon a socio-ecological perspective to better reflect how underlying determinants and their corresponding pathways interact and for the need to create environmental conditions that support and promote effective and sustainable engagement in health behaviour. The potential of ecologically based multilevel interventions to increase population levels of physical activity is of great public health significance. In today's modern public health, we cannot continue to simply deal with illness after it appears, or keep exhorting individuals to change their attitudes and lifestyles, when the environment in which they live and work gives them little or no choice or support to do so. Multilevel interventions based on ecological models and targeting individuals, social environments, physical environments, and policies must be implemented to achieve population change in physical activity and by their very nature are trans-disciplinary and multi-agency.

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Centre for Research and Action in Public Health, The University of Canberra – the first three in a collection of six articles

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Approaches to 'fixing' the problem will require much more than the health sector alone can deliver and requires significant multi-agency cross government collaborative working across public, private and community sector organisations. More emphasis is being placed on coherent strategies that facilitate the collective pooling of resources, expertise and alignment of limited funding. Terms such as interagency or multi-agency cooperation, collaboration, coordination, and interaction have become permanent features of government public health policy. However, much of this is rhetoric and needs to be turned into reality with "whole of government" approaches to the prevention of chronic disease and promotion of good health which are grounded in a socio-ecological framework.

1. Vos T, Carter R, Barendregt J, Mihalopoulos C, Veerman JL, Magnus A, Cobiac L, Bertram MY, Wallace AL, ACE-Prevention Team (2010). Assessing Cost-Effectiveness in Prevention (ACE-Prevention): Final Report. University of Queensland, Brisbane and Deakin University, Melbourne.

2. Mental health problems arising in childhood and adolescence: Current and future human and economic costs

Adjunct Associate Professor John Goss

We know that the burden of mental illness is high in the Australian community, and that most mental health problems originate in childhood and adolescence. For example, it is estimated that 49% (1,470) of the 3,030 incident cases of schizophrenia in 2003 arose in young people aged less than 25 years. And for anxiety and depression, 42% of the 111,000 incident cases in 2003 were among those aged less than 25 years.

So it is of interest to consider the following questions: What is the burden of disease from a range of types of mental health problems for children and adolescents, now and into the future? Which conditions account for the greatest burden, and which affect the greatest number of people? What is the expenditure by the health system for mental health problems at present and what is it expected to be in the future (up until 2032-33) on business-as-usual assumptions?

These questions are being answered through a project being carried out jointly between The University of Canberra and The University of Western Sydney and funded by Medibank Private. The seven disorders for which expenditure can be estimated are: alcohol dependence and harmful use; substance use disorders, excluding alcohol; schizophrenia, anxiety and depression; bipolar disorder; eating disorders; and attention deficit hyperactivity disorder (ADHD).

Once the questions above are answered, the next stage of the project is to estimate, from reviews of the scientific literature, the extent to which selected interventions would be expected to reduce the incidence, prevalence and severity of particular mental conditions in children and adolescents. The reduction in the burden of disease to the year 2032-33, and the reduction in health system costs, that these selected interventions produce will then be calculated. The monetary and health benefits from reducing the incidence, prevalence and severity of mental conditions will be compared with the costs of the selected interventions to ascertain which of the interventions are the most cost-effective.

The burden of disease part of this project is based on work done by Drs Theo Vos, Stephen Begg and others at The University of Queensland. The health system expenditure aspect of this work is based on work done by John Goss at the Australian Institute of Health and Welfare and being continued at the Centre for Research and Action in Public Health.

Centre for Research and Action in Public Health, The University of Canberra – the first three in a collection of six articles

3. Driving culture: A public health imperative

Dr Ruth Wright

Road traffic crashes cost the ACT and Australian community socially and economically. On average, one person is killed on ACT roads every 26 days with 2010 already recording an even higher rate. Whilst social costs may be incalculable, road injury and death has an economic cost of at least \$180 million per year for the ACT. Additionally, the road accident burden in Australia (deaths and injury taken together) for those aged 15 to 34 years accounts for 7 per cent of the burden of disease and injury for this age group, their second biggest health problem after anxiety and depression.

The ACT Government is working towards a “Vision Zero” approach. This requires a mind-shift: road deaths and serious injury can no longer be considered a natural consequence of high-speed mobility. But how can we eliminate such casualties?

Vision Zero-type approaches suggest that community support and adopting a safe driving culture are essential. Some think that the only way to do this is to have tougher laws and increased enforcement. Such an approach can, indeed, be an important part of the solution. The compulsory use of seat belts in Australia in the 1970s was a highly successful road safety initiative employing legislation and enforcement as the primary tools for behaviour change. This initiative, coupled with a community education campaign, has been credited with a reduction in road fatalities by almost one-half by the mid 1980s. Awareness and behaviour altered dramatically in a relatively short period of time. Further, seat belt-wearing rates increased as time went on, long after the legislation was first introduced. In addition to wanting to avoid a fine, people realised it was *socially unacceptable* not to use one’s seat belt. Australians adopted a culture (or expectation) of seat belt use by all.

But tougher laws are not the only approach we will need. Understanding the culture that we adopt as a society, or as distinctive groups within our society, may help address the persistence of death and serious injury on our roads. According to Professor Don Aitkin of the NRMA-ACT Road Safety Trust, we need “a candid look at our driving culture”¹. Our preliminary research suggests that there may be a *culture of entitlement* by some ACT road users. That is, some groups may feel they have more right to use the road as they wish than do others. For instance, those riding bicycles and those driving cars sometimes hold conflicting views about their rights to road use; such conflict may contribute to more aggressive road use behaviours by *both* groups. Similar dynamics may apply to different age, occupational or even residential groups.

These emerging hypotheses offer significant opportunity for understanding factors that may influence dangerous road use. It is now essential, therefore, to investigate whether these different cultures exist and how they affect road use behaviour. With greater understanding, we may be able to better engage all road users in safe road use behaviour. Like it or not, we use roads in collaboration (or exasperation!) with many others. Understanding the social processes that guide our road use behaviour is one more weapon we can use against a public health enemy that devastates families and communities in Australia every day.

1. *CityNews*, August 19-25, 2010, p. 11.

Writin' Up Health

In August a three day residential workshop was offered titled *Tiddas Writin' Up: Indigenous Women and Educational Leadership*. 'Tiddas' in this context re-inscribes the white way of knowing the familial relationship of 'sister' in the Indigenous generic language term of 'Tidda'. The workshop was funded by the Australian Learning and Teaching Council (ALTC) and led by Bronwyn Fredericks (Queensland University of Technology) and Nereda White (Australian Catholic University).

This workshop was consistent with the ALTC objectives of fostering the development of leadership capacity by allowing the sharing of Indigenous women's knowledge and learning and providing networking experiences to support professional development. Specifically, it promoted and supported strategic change in higher education and research by strengthening the participation and leadership capacity of Indigenous women academics in scholarly writing. The workshop was open to all Aboriginal and Torres Strait Islander women working in all disciplines in higher education or research institutes and organisations. A number of Indigenous women working and researching in Indigenous health attended the workshop. They look forward to writing more and to publishing more through a range of mechanisms.

The *Tiddas Writin' Up* workshop built on and complimented the *Tiddas Showin' Up, Talkin' Up and Puttin' Up: Indigenous Women and Educational Leadership* project developed by Tracey Bunda and Nereda White which was also funded by the ALTC (2008-09). Throughout the former project and the *Writin' Up* project the idea of publishing a collection of Indigenous women's writings was tabled. It was thought that an edited collection would offer Indigenous women, as Indigenous women academics, a powerful way to express their concerns, ideas and experiences. The edited collection is now being compiled and will be published in 2011 by the *Journal of Australian Indigenous Issues*. A number of women who work in health will be published within the collection.

For further information contact Bronwyn Fredericks at: b.fredericks@qut.edu.au



Photo: Tiddas Writin' Up: Indigenous Women and Educational Leadership Workshop, Brisbane, 2010. Photo by Rhonda Hagan.

Democracy in action or a 'gobfest'? What is so wrong with a citizens' assembly?

Rebecca Tooher & Jackie Street, Discipline of Public Health, School of Population Health and Clinical Practice, The University of Adelaide

Earlier this year we watched the response to Julia Gillard's idea of a citizen's assembly. Across the board there was a high degree of scepticism. Many political commentators and journalists, and quite a lot of the public it would seem, saw the idea as a political ruse, a way of delaying policy commitment.

But what particularly interested and surprised us was the strong resistance exhibited by punters in online discussion forums and vox pops on radio and television. Generally people like to be consulted about things that are going to affect them, so why the vehement opposition to a citizens' assembly?

Some saw a citizens' assembly as a 'communist plot' and opposed it on purely ideological grounds while others believed parliament itself provides a satisfactory citizens' assembly. Some believed the existence of a scientific consensus meant that no further discussion was required and others questioned the representativeness of a citizens' assembly and doubted the qualifications of a citizen in a complex technical area like climate science.

What was abundantly clear from reading these comments is that there is clearly no consensus about this. We can't know whether these comments are reflecting views in the community more broadly but, if they are, then it would seem that Julia Gillard's instinct about the need to create community consensus may have been right.

While there may be a consensus that something needs to be done about climate change there is less agreement about what that something should be. There is no doubt that whatever policy is finally adopted, there is going to be an impact on the community. Whether this is a price on carbon, a carbon tax or some sort of "direct action", there will almost certainly be winners and losers. No matter which policy or mix of policies is chosen, some parts of the community (possibly the most disadvantaged) will be more adversely affected than others.

These are important issues that the community needs to understand and discuss. At the moment this is difficult because opinion is polarised. Either you believe in human-induced global warming or you don't. Either we should act on climate change or we shouldn't. You are a climate sceptic, a climate change denier, or a greenie. If you don't know a lot about it how do you decide?

This is the point of a citizens' assembly. A representative group of people are chosen by widely accepted sampling strategies, often including stratified random sampling. Over a period of days the group engages in an informed discussion about the important issues surrounding climate change policy. The members of the citizens' assembly are regarded as experts on their own lives but a range of other expert views are also presented.

The government will still make the policy. The citizens' assembly would simply assist in the process by providing an insight into which policy formulations an informed group of people representative of the community would be prepared to live with. If it works, this would mean that politicians and policy makers would have a better understanding of the community's views about climate change and various ways of tackling it. Ultimately this could



Jackie Street



Rebecca Tooher

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lead to a bipartisan approach to the issue.

The job for those of us who are interested in the practice of deliberative democracy is how do we engage with these people who think the whole idea is useless? If the whole point of engaging the community is to, well, engage the community, what do we do about people who reject the idea out of hand?

It would be a pity if an opportunity for a more open genuinely informed debate about climate change is missed simply because the idea was suggested by one side of the political debate in the heated atmosphere of an election campaign. Even more so, if the idea of a citizens' assembly is rejected out of hand on the basis of a lack of understanding of its purpose and processes.

A hung parliament, where every decision and process will be scrutinised, shaken and stirred, would seem like the ideal time for the consensus approach of a citizens' assembly on such a contentious issue as climate change policy.

Establishing Aboriginal health research priorities in Victoria

The Victorian Aboriginal Community Controlled Health Organisation (VACCHO) undertook a Social Determinants Research Project to build the capacity of the Victorian Aboriginal community to effectively engage in health research in an equitable and productive way. This project was funded by the then CRC for Aboriginal Health (now the Cooperative Research Centre for Aboriginal and Torres Strait Islander Health (CRCATSIH)). VACCHO is the Victorian peak body for the Aboriginal Community Controlled Health Organisation sector, with 24 member organisations. VACCHO works to identify needs, advocates, auspices state-wide projects, negotiates and initiates approaches to governments (both State and Federal) and other non-government organisations and institutions, offers training and professional development and a range of other activities.

The Social Determinants Research project primarily sought to develop a research agenda which was based on identified community need by the Aboriginal Community Controlled Health Organisations and their respective communities in Victoria in an attempt to promote research which addresses the social determinants of Aboriginal health. That is, issues such as education, employment, income, racism, housing and so on that impact on the health and wellbeing of Aboriginal peoples. These determinants reflect on the holistic model of primary healthcare that the Aboriginal Community Controlled Health Organisations undertake and directly affects their capacity to deliver services for and with their communities. This project also was undertaken within localised contexts with a view for a State-wide research approach.

VACCHO has now published the findings from the project and in doing so demonstrates, along with its member services, their willingness to be involved in ethical research that reflects community need and that, through appropriate engagement, partnership, direct benefit and outcomes and the community, will participate in funded research. *The Strategic Directions of the Social Determinants of Aboriginal Health Report* prepared by Rebecca Edwards, Karen Adams, Bronwyn Fredericks and Ray Mahoney can be downloaded at:

http://www.vaccho.org.au/rw_documents/44pp%20A4%20Event%20Report.pdf

For further information about this report contact Lisa Briggs (lisab@vaccho.com.au) or Graeme Fletcher (graemef@vaccho.com.au) via their emails or on 03 9419 3350.

Goreen Narrkwarren Ngrn-toura – Healthy Family Air: A Literature Review

A literature review has been published by the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) and the Centre for Excellence in Indigenous Tobacco Control (CEITC) on smoking reduction amongst pregnant Aboriginal women. VACCHO commissioned the literature review for its *Goreen Narrkwarren Ngrn-toura – Healthy Family Air* project which seeks to increase the understanding and knowledge of smoking cessation, create supportive environments with Aboriginal health organisations, support Aboriginal women to quit smoking in pregnancy and support young mothers not to take up smoking. The project and the literature review were funded by the former Victorian Department of Human Services (now the Department of Health).



The literature review provides an overview of what is known about the determinants of tobacco use amongst Aboriginal and Torres Strait Islander people, as well as the barriers and motivations to quitting. It reviews the current evidence around tobacco control prevention and cessation initiatives in both the mainstream and Aboriginal and Torres Strait Islander contexts. Based on the literature, key tobacco control activities with pregnant Aboriginal women should include:

- Strategies that de-normalise smoking in Aboriginal communities, and provide skills and supportive environments for pregnant women to quit.
- Interventions provided in the primary health care setting to advise and support the women to quit. Such interventions may include: brief interventions and behavioural counselling (for example, Nicotine Replacement Therapy (NRT) and Quit courses).
- Training provided to Aboriginal Health Workers to improve their confidence and capacity to deliver both individual clinic-based interventions and community-based tobacco control activities.
- Strategies for Aboriginal Health Workers to support and encourage them to quit smoking themselves, including the development of supportive work environments.
- Multi-component family and community-focused programs that take a broad-based and holistic approach to tobacco control and incorporate components that target families and communities, not just pregnant women.
- The development of policies and protocols in Aboriginal organisations (such as smoke-free workplaces and cars) to provide supportive environments in which to deliver smoking cessation programs.

The artwork on the front of the report is by Anjee-Lee Solomon. Anjee has captured within her artwork the essence of Aboriginal woman's strength in battling in their journey to quit smoking.

The *Goreen Narrkwarren Ngrn-toura- Healthy Family Air: A Literature Review to Inform the VACCHO smoking in Pregnant Aboriginal Women Research Project* can be freely downloaded from the VACCHO website at http://www.vaccho.org.au/rw_documents/Healthy%20Family%20Air%20Review-FINAL%20WEB-2.pdf It can also be found on the Australian Indigenous HealthInfoNet.

For information about *Goreen Narrkwarren Ngrn-toura – Healthy Family Air* contact the Project Coordinator Ms Summer Finlay at summerf@vaccho.com.au or on (03) 8413 7900.

National Aboriginal and Torres Strait Islander Women's Health Strategy

The *National Aboriginal and Torres Strait Islander Women's Health Strategy* was launched in May and is still being disseminated throughout the country. Dr Bronwyn Fredericks (Queensland University of Technology & Monash University), Dr Karen Adams (Victoria University) and Ms Sandy Angus (Australian Women's Health Network, AWHN) led the development of the Strategy with the Australian Women's Health Network Aboriginal and Torres Strait Islander Women's Talking Circle.

The work was funded by the Australian Government through the Women's Leadership and Development Program to undertake consultations with Aboriginal and Torres Strait Islander women and to provide input into the new National Women's Health Policy (AWHP).

Over 400 Aboriginal and Torres Strait Islander women participated in consultations to identify their priorities and needs. The Action Areas and Recommendations presented in this Strategy were raised and discussed by the women who contributed through the consultation process. The Strategy is available at: <http://www.awhn.org.au>

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Acronyms that are regularly used in the PHAA Newsletter

PHAA - Public Health Association of Australia Inc.

SIG - Special Interest Group

AIHW - Australian Institute of Health & Welfare

WHO - World Health Organization

ACT - Australian Capital Territory

NSW - New South Wales

VIC - Victoria

WA - Western Australia

TAS - Tasmania

SA - South Australia

NT - Northern Territory

QLD - Queensland

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Articles appearing in *intouch* do not necessarily reflect the views of the PHAA but are intended to inform and stimulate thought, discussion and comment. Contributions are welcome and should be sent to:

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