CONTENTS

NDIS & Indigenous Communities ........................................ 3
Foetal alcohol spectrum disorder ....................................... 5
Strangers in their own land ................................................. 6
FASD, disability & the criminal justice system .................... 7
Guddi Project ................................................................. 9
My unsung hero ............................................................. 10
Justice or injustice system? .............................................. 11
Never give up ............................................................... 11
An apology .................................................................. 12
Cultural violence ........................................................... 13
First peoples disability network .......................................... 13
Torres Strait Islanders ...................................................... 14
Land rights .................................................................. 14
Crafting one’s future ....................................................... 15
Going for gold ................................................................ 16
Attention & concentration ............................................... 17
A journey toward pride .................................................... 19
Getting the vote ............................................................. 20
A black history .............................................................. 21
Short-term memory tips .................................................... 22
Murri Dan .................................................................... 23
Inside stories ................................................................. 24
Here’s to your health ....................................................... 25
Brain injury & dementia ................................................... 27
Behind the exterior ........................................................ 29
Stolen generation ........................................................... 29

Evan’s Fight to Not Only Survive But To Achieve A Lifelong Dream

CRAFTING ONE’S FUTURE

Gabie is a talented and artistic son who experiences life with a level of independence

A Journey to Ward Pride

Without pride in ourselves we cannot create pride...

Guddi Project

An Innovative Approach to Health, Disability and Human Rights

Visual Difficulties: Visit www.synapse.org.au and view the free online version which can be expanded on screen.

Disclaimer: While all care has been taken to ensure information is accurate, all information in this publication is only intended as a guide, and proper medical or professional support and information should be sought. Synapse will not be held responsible for any injuries or damages that arise from following the information provided. Material within does not necessarily reflect the policies of Synapse or the staff and Board of Management. References to other organisations and services do not imply an endorsement or guarantee by Synapse.
Indigenous Australians experience more than twice the rates of disability than other Australians. After taking into account age differences between Indigenous and non-Indigenous populations, the rate of disability among Indigenous Australians is almost twice as high as that among non-Indigenous people.

By any measure, Indigenous Australians with a disability are among the most disadvantaged members of the Australian community, as quoted from the First Peoples Disability Network (FPDN). They often face multiple barriers to meaningful participation in their own communities as well as the wider community, facing double disadvantage because of discrimination on the basis of their Aboriginality as well as their disability.

Synapse is continuing to build partnerships with Indigenous people in order to build on their ideas, strengths and leadership. This will go a long way to finding practical answers to long-standing health problems such as Acquired Brain Injury.

Thanks to those who shared their stories. These issues require a multi-faceted approach and a long-term commitment to build on promising gains that have been seen in recent years. Please join us in working together to build a better future for all Australians.

In this issue of Bridge we refer to Australia’s First Peoples as Aboriginal and Torres Strait Islander people and Indigenous Australians. Both terms are applied with deep respect and acknowledgment of the distinct identities and different ways Australia’s First Peoples contribute to Australia.

We also thank Gary Radler (www.garyradler.com) for his kind permission to use photos in this issue from his extensive Indigenous images portfolio.

Jennifer Cullen, CEO of Synapse

We can help you manage your care funding.

To assist those seeking to make the most of their disability funding, be it NDIS or a private scheme, we took the initiative to develop Synapse Options. A range of individualised services designed to take the stress out of planning, facilitating and administering disability care funding.

With our assistance you maintain control and choice over both your funding and care without any added stress... And really, isn’t that the whole point?
The prevalence of disability amongst Indigenous Australians is significantly higher than of the general population. Until recently the prevalence of disability in Indigenous Australian communities has been only anecdotally reported. However a recent report by the Commonwealth Steering Committee for the Review of Government Service Provision made the following conclusions:

The proportion of the indigenous population 15 years and over, reporting a disability or long-term health condition was 37 per cent (102,900 people). The proportions were similar in remote and non-remote areas. This measure of disability does not specifically include people with a psychological disability.¹

Why disability rates are so high
The high prevalence of disability, approximately twice that of the non-indigenous population, occurs in Indigenous communities for a range of social reasons, including poor health care, poor nutrition, exposure to violence and psychological trauma (e.g. arising from removal from family and community) and substance abuse, as well as the breakdown of traditional community structures in some areas. Aboriginal people with disability are significantly over-represented on a population group basis among homeless people, in the criminal and juvenile justice systems,² and in the care and protection system (both as parents and children).³

Community-based action
The First Peoples Disability Network (FPDN) argues passionately that for positive change to happen the change must be driven by community itself. It cannot be imposed or developed by an external service system that these communities have little or no experience of in the first place.

Throughout many communities across the country Indigenous Australians with disabilities have been supported and accepted as members of their communities. However it is the necessary support resources that many communities lack. Also the service system tends to operate from a ‘doing for’ as opposed to ‘doing with’ approach which only further disenfranchises communities.

Potential of the NDIS
The NDIS does have the potential to address some of these concerns by providing people with the opportunity to self-direct their funding for instance. The challenge in this area is that many within these communities have had little or no experience in self-managing funds.

It must be remembered that in many ways things are starting from an absolute baseline position. This is reflected by the fact that very few Indigenous Australians with disabilities have an understanding of the language of the disability service system for example. So it is the view of the FPDN that the application of the NDIS in Indigenous communities will need to have a different look and approach to what is advocated for with regard the rest of the Australian population. It may be that the application of the NDIS in these communities takes a longer process. But the FPDN argues that it is critical to get it right as it is the experience of many Indigenous Australians that they are usually the first to be blamed when new programs are not taken up by Indigenous Australians.

The FPDN has developed a ten point plan for the implementation of the NDIS for Indigenous Australians with disabilities. The development of this ten point plan is based upon extensive consultation as well as drawing upon the decade long experience of the FPDN in advocating for the rights of Indigenous Australians with disabilities. It is our intention to publicly launch this plan later in the year.
Ten-point plan
Recognise as the starting point is that the vast majority of Aboriginal people with disability do not self-identify as people with disability. This occurs for a range of reasons including the fact that in traditional language there was no comparable word for disability. Also that many Aboriginal people with disability are reluctant to take on the label of disability particularly if they may already experience discrimination based on their Aboriginality. In many ways disability is a new conversation in many communities therefore with regard the NDIS we are starting from an absolute baseline position. And as a consequence change in this area may evolve on a different time line to that of the main part of the NDIS.

Awareness raising via a concerted outreach approach-informing Aboriginal people with disabilities, their families and communities about their rights and entitlements. As well informing communities about the NDIS itself and how to work this new system effectively. There is simply no other way to raise awareness than by direct face-to-face consultation. Brochures and pamphlets will not do the job in this instance.

Establish an NDIS Expert Working Group on Indigenous Australians with disability and the NDIS. In recognition of the fact that there is a stand alone building block for the NDIS focused upon Indigenous Australians with disabilities the FPDN views it not only as critical but logical that a new Expert Working Group be established. The new working group would operate in the same way the four current working groups do – it would be chaired by two members of the National People with Disability and Carers Council. To ensure its effectiveness but also critically to influence prominent Aboriginal leaders as well as the disability sector, members would be drawn from Aboriginal leadership as well as prominent disability leaders. The FPDN believes such an approach is warranted not only because of the degree of unmet need that is well established but also because this has the potential to be a very practical and meaningful partnership between government, the non-government sector and relevant communities.

Build the capacity of the Non-Indigenous disability service system to meet the needs of Indigenous Australians in a culturally appropriate way. Legislate an additional standard into the Disability Services Act focused upon culturally appropriate service delivery and require disability services to demonstrate their cultural competencies.

Research including into the prevalence of disability and a range of other relevant matters. Critically this work must be undertaken in partnership with Indigenous Australians to ensure a culturally appropriate methodology. There remains very little reference material about disability in these communities and this needs to be rectified to ensure that there is a true picture of their lived experience.

Recognise that there already exists a workforce in many Indigenous communities that continues to do important work-often informally. This work needs to be valued and recognized with the potential for the creation of employment opportunities in some communities.

Recognise that it’s not always about services. Many communities just need more resources so that they can continue to meet the needs of their own people with disabilities. There may be perfectly appropriate ways of supporting people already in place, however what is often lacking is access to current technologies or appropriate technical aids or sufficient training for family and community members to provide the optimum level of support.

Recruitment of more Aboriginal people into the disability service sector.

Build the capacity of the social movement of Indigenous Australians with disabilities by supporting existing networks and building new ones in addition to fostering Aboriginal leaders with disabilities. These networks play a critical role in breaking down stigma that may exist in some communities but are also the conduits for change and will be integral to the successful implementation of the NDIS in these communities.

Aboriginal ‘Launch’ sites focused upon remote, very remote, regional and urban settings. It is critical that this major reform be done right. Therefore it is appropriate to effectively trial its implementation. To this end the FPDN can readily identify key communities that would be appropriate as trial sites.

INDIGENOUS COMMUNITIES - DISABILITY INSIGHTS

In traditional language there was no comparable word for ‘disability’ – suggesting acceptance as part of the human experience. As a result, there is a lack of familiarity with disability sector terminology. Fear of being judged, having a family member removed, or a perceived negative label of ‘disability’ creates reluctance to seeking assistance – particularly if they already experience discrimination based on their Aboriginality.

There is no consensus on the number of Aboriginal people with intellectual disability in the criminal justice system. However, a 1996 report by the Law Reform Commission noted that 12-13 per cent of the prison population experienced an intellectual disability.
Alcohol poses many risks if consumed during pregnancy, and these risks are not limited to any particular community. The lack of awareness-raising, prevention and investment that should have been made in early childhood is now resulting in expensive services that are doing little to improve the quality of life of people affected.

Fetal Alcohol Spectrum Disorder (FASD) is undoubtedly the most under-reported and devastating health issue in Australia today. The cost of ignoring affected children before birth and across generations is proving to be enormous, while the alcohol industry donates to political parties and buys protection from responsibility. Their business practices have damaged babies’ brains in a way that will cost billions of taxpayer dollars in the future.

Alcohol is a teratogen – an agent or factor causing malformation of an embryo, such as:

- Tobacco
- Cannabis
- Toluene e.g. paint solvents
- Codeine
- Caffeine e.g. Coca Cola.

Pregnancy and the first three years are the most rapid times for brain growth, so care, nurturing and comfort are critical. There is no safe amount of alcohol to use in pregnancy and total abstinence is recommended, but mothers receive mixed messages.

Few doctors in Australia are diagnosing these disorders despite increasing numbers of young people poorly achieving at school and becoming involved early with the criminal justice system. Research has shown that the majority of doctors do not know how to diagnose FASD. In fact, it has been called the great masquerader as FASD often gets misdiagnosed as another problem.

**FASD & human rights**

As Nelson Mandela once remarked, you can judge a society by the way it treats its children – don’t look too closely at Australia.

While we have ratified the UN Convention on the Rights of the Child (1989), Australia still does not have a coherent Bill of Rights in its Federal Constitution. There are in fact numerous specialised bodies dealing with privacy, anti-discrimination, and mental health, yet there is no recognition of FASD, a largely preventable condition.

**Prevalence of FASD**

Accurate statistics are hard to gather when so little research has been done, but there are estimates of 140,000 Australians living with FASD.

The Lililwan Study conducted several years ago found that one in every three Aboriginal children living in the Fitzroy Valley of WA were affected by FASD – the world’s highest known prevalence rate of FASD.

Efforts to secure funding for a mainstream prevalence rate have been ignored. This is largely attributed to the power of the alcohol industry’s lobbying of politicians and the donations they make to political parties which give them protected from responsibility status. The concentration of research efforts is then redirected to the most vulnerable population group – Indigenous Australians. That becomes the sole reason for making FASD “just an Indigenous issue”.

**Features of FASD**

Physical feature changes to the skull, face, genitals, teeth, brain and skeleton are common, as are problems with vision, hearing, liver, heart and skin. Cognitive problems are similar to many other types of brain injury, and along with the physical features can lead to secondary characteristics such as:

- Fear, anxiety, avoidance and withdrawal
- Victimization of and by others
- Truancy, unemployment, homelessness
The criminal justice system & FASD

Individuals with FASD are becoming involved with the criminal justice system at an unprecedented rate – the nature of their brain injury often makes it difficult for them to stay out of trouble with the law. The average age that children with FASD begin having trouble with the law is 12.8 years old.2

Offenders with FASD do not know how to deal with police, lawyers, judges, social workers, psychiatrists, corrections and probation officers and they do not intentionally set out to break the law. They lack impulse control, ability to predict consequences of their behavior, have difficulty planning, connecting cause and effect, empathizing, and in taking responsibility. They often repeat the same mistakes without learning from them, cannot make good judgments, are easily side tracked and have high rates of addiction and mental health problems including suicidality. They may have a tendency toward explosive episodes, be vulnerable to peer pressure and exhibit inappropriate sexual behaviours.

The resulting legacy of intergenerational alcohol, tobacco and cannabis use has led to a situation of grave disquiet in communities specially those where there is long-term poor health, feelings of despair and hopelessness, ongoing substance abuse and from it endemic violence. In many there are one to two generations in some families unable to adequately fulfill their parenting roles even to care for themselves adequately, due to alcohol and other substance abuse.

What needs to be done

When the problem has been neglected for so long, any solutions will take a sustained multi-faceted approach with years of dedicated effort. Any strategic plan needs to address:

+ Effective family planning
+ Progressive interventions e.g. learning problems
+ Customized family support plans
+ Progressive interventions
+ Unconditional support
+ Prevent worker burnout
+ National awareness campaigns
+ Appropriate legislation as with cigarette marketing.

Aunty Janet Hammill is a Research Fellow at the Centre for Public Health at Queensland University of Technology, an Indigenous ethnographer and acclaimed participatory action researcher.

Indigenous stock imagery used with permission. garyradler.com

FOOTNOTES
1 (June Oscar, plenary presentation, NIDAC Conference, 4 June 2014)
2 “A Proposed Model Standard for Forensic Assessment of Fetal Alcohol Spectrum Disorders,” 2010

For who grew up separated from their families of origin as a result of being placed in institutions (often as a result of their disability) – lack of connection with culture, indigenous community and family is a common theme. An institution is a very different environment and it can be difficult to move between the two. For some, being placed into an institution was the cause of their disability or mental health issues. Other people left their communities later in life when their families could no longer support them. For example, an older man with an intellectual impairment from Far North Queensland moved to Brisbane to live in a supported accommodation service. Some felt unsafe in their own communities or clans and/or had experienced exploitation as a result of their disability – one person who attended a yarning circle was very uncomfortable letting people know what clan he/she belonged to. This person felt unsafe within their community as they had moved away from their clan. “I am displaced and don’t belong anywhere.” Families can also become isolated from their communities and lose their connections to their culture.

This is an edited excerpt from “Tracks in the Shifting Sands”, a report from the Aboriginal and Torres Strait Islander Disability Network of Queensland. For more information, contact the Queensland Disability Network by calling 07 3252 8566, visiting www.qdn.org.au or emailing qdn@qdn.org.au

TYPICAL EFFECTS OF FASD

+ Memory problems and difficulty storing & retrieving information
+ Inconsistent performance (‘on’ & ‘off’) days
+ Impulsivity, distractibility, disorganization
+ Ability to repeat instructions, inability to put them into action (‘talk the talk but don’t walk the walk’)
+ Difficulty with abstractions, such as math, money management, time concepts
+ Slower cognitive processing deficits
+ Slow auditory pace
+ Developmental lags (younger than chronological age)
+ Inability to predict outcomes or understand consequences.
Fetal Alcohol Spectrum Disorder (FASD) is not officially recognized as a disability in Australia. This precludes sufferers from automatic disability supports and benefits. This challenges Article 25 (b) of the Convention on the Rights of Persons with Disability ratified by Australian in 2008. Declaring FASD a disability will enable appropriate disability policy, service development and reform in accordance with the Convention. This also has implications for how people with FASD will be treated in the criminal justice system including assessing responsibility, guilt and moral culpability.

**Within the criminal justice system**

Recognizing FASD as a disability has significant implications for the justice system and the way its services are delivered. At all points in the criminal justice process, disability services with expertise in FASD should fulfill a key collaborative function. This should include timely assessment of FASD and the implementation of long-term post-diversion support services.

**Identification**

Many legal professionals lack an adequate understanding of disabilities and have been found to have limited understanding of FASD. Lawyers need to accurately assess and present the nature and level of disability/impairment to the court. They also need to be able to communicate effectively with a person with FASD. Expert witnesses with FASD experience could have a valuable role in the provision of information about diagnosis and appropriate responses to FASD.

**Diversion**

For people with FASD, involvement in the court and prison system can begin a trajectory of criminal activity leading to repeat offending and lifelong episodes of imprisonment. Diversionary programs aim to divert the offender away from the criminal justice system. Innovative sentencing mechanisms with some evidence of benefit include circle sentencing, Aboriginal and drug courts, children’s Koori courts. Outcomes can differ markedly depending on the attitudes of court personnel and officials toward people with disabilities and their willingness to use discretionary processes where available. Barriers to diversion for FASD offenders, particularly Indigenous Australian offenders, include the likelihood they have multiple charges and previous convictions; present with substance misuse coexisting with mental health problems; often do not recognise their guilt; and are more likely to have been convicted of a serious crime. The problem is exacerbated in rural and remote areas.

**Justice reinvestment**

FASD prevalence rates within the criminal justice system are unknown. Rates are thought to be high due to the social and behavioural problems experienced by people with FASD. Justice reinvestment recognizes that removal of people from communities reduces social capital and does not reduce offending. It seeks to address this problem by re-allocating funds from the prison system and invests these resources in programs and services that are aimed to address the underlying causes of crime and to build and strengthen communities. In doing so it seeks to meet the needs of the community to be safe; as well as supporting people not to offend in the first place and reducing recidivism.

---

**FASD CASE STUDY**

Troy is a 27-year-old Indigenous man whose early childhood experiences included the suicide of his alcoholic father, uncles and an aunt, and the suicide of peers throughout his adolescence and adulthood. Troy was diagnosed with FASD in 2002 by a child development specialist who stated:

"Troy appears to have little insight into his own predicament. His capacity for planning is limited and he lives in a perpetual present. His behaviour is often impulsive … he had little sense of long term future direction. His background has been highly prejudicial. There is a mixture of sniffing, alcohol, abuse, neglect, inconsistency and a variety of other factors all known to be causal for the problems he is currently experiencing … If [Troy] were a Caucasian child presenting with the same spectrum of problems we would classify him as extremely disabled. Troy’s poor executive functioning, deficits in impulse control and inability to relate behaviour to outcomes compounds his poor insight and judgement. He suffers ongoing addictions to inhaled and injected substances, mental health issues, inability to manage money and illiteracy. He has minimal chances of employment. These recognized secondary disabilities were compounded by a lack of meaningful early intervention. From the age of eleven, Troy has been involved with the legal system with frequent incarceration totalling more than ten years, including months in solitary confinement. He has been the victim of sexual abuse in care and in custody. This case study demonstrates that the absence of recognized and customized interventions for people with FASD results in secondary disabilities including mental health problems; disrupted school experience and learning; criminality; inappropriate sexual behaviour and drug and alcohol addictions."
Bail
People with FASD are at risk of prolonged remand due to unstable housing, poor decision making and impulsive behaviour. Reduced social integration increases their chance of coming into contact with negative role models and the likelihood of cyclic criminality and anti-social behaviour. Long-term remand is costly with estimates of the average cost of 5 months in remand at $39,000. While bail is a method of diverting an individual, it requires a capacity to meet bail conditions including regular reporting which is extremely challenging for many people with FASD.

Conferencing & FASD Case Management
Conferencing confronts young people with their behaviour and provides avenues for direct reparation and restitution of victims. It may be used as a mechanism for diverting the individual from the criminal justice system or a vehicle for directing cases into an alternative process of community-based justice. While people with FASD may appear able to negotiate the court system, it is likely they will need a competent support person to assist them throughout the criminal justice process. They may need a collaborative approach between a range of stakeholders when participating in the court process. FASD court liaison officers with an understanding of FASD, neurocognitive disability and the legal system may assist.

Sentencing
A diagnosis of FASD should be a crucial consideration in sentencing and should inform judgments that weigh up the ever-present reality of the risk of reoffending with the needs and human rights of the offender with FASD. Where probation is considered, the court will need to take into account that the person with FASD may not understand the conditions of a suspended sentence, and may need the support of people within the justice and disability sectors in order to comply with probation conditions. Opportunities for reoffending and problematic associations may be reduced or eliminated by the introduction of strict routines and supervision. Existing models designed specifically for Indigenous young people, including diversionary programs with appropriate links to community controlled health services and programs that support families in the re-integration of offenders, may provide useful templates.

Release
Research into the management of at risk young offenders demonstrates that systematic and developmentally informed risk assessments, selectively assigning intensive intervention to the highest risk offenders, using proven interventions and treatment strategies, and applying rigor in implementation and follow-up may reduce offending. People with FASD who are assessed as having a higher probability of reoffending are often excluded from treatment services that target criminogenic needs. The structured environment of prison which may assist people with FASD to manage their behaviour is frequently unavailable on release.

Conclusion
FASD is a public health problem of epidemic proportions affecting Indigenous and non-Indigenous Australians. FASD is a disabling condition characterized by complex behavioural, cognitive, physical and psychological problems including early onset chronic disease and poor mental health and the heightened risk of criminality. FAS and FASD should be considered within a human rights and disability framework. A holistic and multidisciplinary approach would include prevention and reduction of the incidence of FASD, improved quality of life of people with FASD, and reduced involvement in the justice system. Where this is not achieved, provision of a suitably structured justice system should ensure timely diversion from and innovative alternatives to long-term and repeated incarceration.

We argue that these solutions will in part reside in the recognition of FASD as a disability, prevention and early intervention strategies, the establishment of an evidence base and the adoption of a disability approach to FASD within the criminal justice system.


Indigenous stock imagery used with permission. garyradler.com
While the introduction of the NDIS involves almost 100,000 Queenslanders, this does not currently include Indigenous Australians who are more than twice as likely to have a disability, and 14 times more likely to be homeless. Part of the problem is there is so little information about the extent and nature of neurocognitive disability amongst Indigenous people. This information is urgently needed to enable State and Commonwealth governments to appropriately and effectively address this issue.

**How the Guddi project works**

Participants in the project receive a culturally safe and appropriate clinical assessment that includes: neurocognitive, medical and functional assessments. Blood and faecal samples are also collected for biomedical examination. Faecal samples enable the identification of human parasite infection which causes a range of serious physical problems and is thought to impact on neurocognitive functioning. Our results may assist individuals and provide important public health data to address this preventable condition.

To understand the lived experience of disability amongst homeless Indigenous people information is also gathered regarding participants’ experiences of neurocognitive disability and homelessness, their understanding and expectations of disability supports, including the NDIS; and barriers and enablers to service usage. This data is collected through formal and informal yarning.

Following completion of the individual assessments participants are informed as to whether they have been assessed as having a neurocognitive disability. The project team explains to the participant, in culturally appropriate language, the nature of their disability or health condition and whether they are eligible for disability supports.

**Findings to date**

Preliminary findings from the project include high levels of complex disability, trauma; and lack of engagement with human services. In addition, none of those who might have qualified for the NDIS were prepared to have that assessment undertaken.

The project has confirmed earlier findings that there is a 100 per cent level of complex acute and chronic illness and neurocognitive disability among the project participants, which is further complicated by inappropriate service delivery, poor access to appropriate services, and inability to adhere to treatment due to poor understanding, lack of appropriate support, and guidance.
There is also a high prevalence of trauma, with participants reporting exposure to childhood trauma including loss and separation from parents and family, sexual and physical abuse, neglect, and harsh physical environments. Most clients had experienced a number of traumatic brain assaults resulting in unconsciousness. The Guddi project will hopefully result in a better understanding of the role of PTSD in chronic homelessness.

Lack of engagement with human services has been documented in previous research. Indigenous participants often do not identify as having a disability although their disability often leads to acute ill-health and appalling quality of life. Participants are suspicious and distrustful of human services, and see no positive value in being referred for assessment. Existing services and interventions to date have been unsuccessful and programs fail to address the needs of Indigenous people with complex disabilities.

**Where to from here?**

In March 2016 the Guddi model and findings were introduced in the NDIS Barwon trial site in Victoria as this approach is cost-effective, builds local expertise and awareness, and offers sustainable, long term benefits to the area in which the research project is undertaken.

Once completed, the Guddi Project should have significant implications for the NDIS’s model of engagement with Indigenous Australians, those who are homeless, and other marginalized people.

It will also provided much needed information concerning the extent and nature of neurocognitive disability amongst Indigenous people and other marginalized groups.

Indigenous stock imagery used with permission. garyradler.com

**MY UNSUNG HEROES**

by Maria Goncet

I love Saturdays as I go swimming with two remarkable women. Well, I like to call it swimming, as it makes me sound normal; however, the correct term is hydrotherapy. When I first saw Shona’s work, I decided to learn more about it. It was then, that we introduced ourselves. I learnt that Shona had been helping these young men who had been in horrific car crashes. I had previously met John at the hospital where I lived, and did my rehabilitation for one year. I immediately wanted to know more about Shona’s work. As soon as Shona told me, she had been training Raj and John for five years, I wanted to find out if she would train me, also. Needless to say, I was over the moon when she accepted. What makes Shona really remarkable is that she has been training a young man called Raj with real results. Raj, who was told he would never walk again is now walking. With Raj’s determination, Shona’s amazing gift, and Raj’s mum always there to hold his hand along the way.

Raj is living proof to me that Doctors sometimes get it wrong.

The other lady who is key to my journey is Jenny. Jenny has been with me for four years, and I often tell her: “Jenny, you have seen the best, and the worst of me.” Without knowing it, Shona, Raj and Jenny give me hope, and encourage me to keep going. More than ever before, I need to be strong, and not let loneliness, and sadness, get in the way of my success. I need to stay focused and keep working hard. Sometimes, it can be strenuous, even lonely. However, I look to my husband and children who support me along the way. It is not an easy thing to live with a brain injury survivor. I throw tantrums, I can be a little irrational, let’s say very, very irrational, according to my husband. However, we do the best we can to keep the family together.

"Come let’s begin to heal, come rest your mind, body and soul and finally come home and find that quiet, peaceful self"
After I came out of hospital and was slowly becoming aware of my surroundings and injury to my brain, I became very depressed. My family were extremely supportive and sought to jolly me along as much as they could.

One of my children gave me a small card when I was in hospital which said “Never give up”. I didn’t give the card much thought when I received it, but I am really glad that I kept it. My experience of life after hurting my brain is a bit like treading water. I have to spend a lot of energy keeping my nose above the water line. If I don’t, then it is easy to just sink into it all. But I don’t want to give up.

Learning to walk is a good example. It was the experience of attempting to use my walking stick on the beach, as I walked along in the sun, that made me angry enough to throw it away. “Blow this for a joke, I’ll just get rid of it”. My initial thought was that this will be the end of the matter. It is easier to sit at home, talk to the dog, watch television and so on. I don’t need to walk anyway.

It wasn’t long before I discovered that I did need to walk. My whole system began to object: dizziness from inactivity, constipation, aches and pains and the like. So, back to the beach. It became my favourite pastime. Half way down the beach, we discovered thousands of pippi shelfish at the tide mark. Shorts pockets became shellfish carriers, and seafood marinara became something to look forward to that evening. My wife loves seafood.

There were pitfalls however (I guess I should say “sandfalls”!). A parachute club uses our beach to land on. I quickly learned that if I looked up and watched the jumps, I soon lost balance, falling backward on the sand. The next step was to move up the beach towards the closest sandhill, and simply lie down on my back for the next half hour. Sun, the sound of waves, a sea breeze, and parachutists landing, often as a tandem jump – what a great way to spend the afternoon.

Instead of giving up, I was able to discover...
a way to relax and enjoy a pastime that I would not have even thought of before. Now, before you begin to think how clever I am to have thought of this, I need to tell you that it was my commando-like wife who would:

+ get me walking
+ encourage me to lie down to watch the parachutes
+ point out that we never used to do this in an earlier life!
+ tell me how fortunate I am to have her!

How right she is. And how glad I am that I listened to her and kept going.

I think there are a number of levels in giving up, none of which are useful to me. There are the ‘little’ giving in events. I think the lying down to watch the chutes or giving up and continuing to walk is a ‘little’ giving in. There are no major repercussions in these little ‘giving up’ experiences.

There are ‘medium’ types such as giving up walking, or giving up going to the gym for my ‘un-gym-jack’ workouts would be a medium one. The really important and ‘big’ types (as I experience them) probably have to do with depression. It is tempting sometimes to just lie on the bed, listen to the radio or iPod, and simply not be bothered to do anything at all. “Why try any more? Nothing seems to change!” “Who cares anyway?”

This becomes a quicksand trap in our lives. When we step into it, wriggle a bit, it sucks us in deeper, and then all my negativity becomes a self-fulfilling prophecy! This is when I need help to get me out of the downward spiral.

All kinds of help are available, from a spouse or friend, your doctor, to Beyond Blue, to Lifeline. We are never really alone. There is always someone who can help us.

So, if you have hurt your brain, or if you care for someone who has hurt their brain, then never give up.

Rick Bowie is a regular contributor to the Bridge magazine.
CULTURAL VIOLENCE

Johan Galtung is a Norwegian sociologist who has explored the meaning of the word “violence” beyond the direct type, such as physically hurting, wounding, maiming or killing.

His work throws new light on the many issues faced by Indigenous Australians. For example, he refers to structural violence as inequality in the distribution of power, exploitation and marginalization through laws, education and religion.

Galtung also refers cultural violence as any aspect of culture that can be used to legitimise violence in its direct or structural form – symbols, language, art, or religion to create oppression. He believes these forms of violence often go hand in hand:

“Cultural violence should be understood as those aspects of culture that can be used to justify or legitimate the use of direct or structural violence. The Stars and Stripes, Hammer and Sickle, flags, hymns, military parades, portraits of the leader, inflammatory speeches and posters are all included in this category”.

Structural violence, also known as institutional violence, is about inequalities within a population, for example, education and legal systems that advantage the dominant group while marginalizing minority groups, espousing Western values, philosophies and ideologies. Also the use of “soft” language in writing history, structural violence occurs when the invaders are referred to as “settlers”, “explorers” or “pioneers”.

Indigenous grandmothers talk about not realizing they were “natives” as their school textbooks had a picture of a “Native”, a man on a cliff holding a spear with one foot on other knee. Others were smarter and read the “Department of Native Affairs” on the mission truck.

Violence is substantially misunderstood and ignored because the definition of violence as most people understand it, is what Galtung defines as “direct” violence such as the well publicized domestic violence within families.

Historically, going to cinema in the early 20th century was another case in point. Despite being segregated and being allowed only to sit down the front, Indigenous Australians also cheered for the cowboys when they routed Indians.

Contemporary governments in Australia continue to structurally violate Indigenous people even if only by ignoring the deprivation they suffer or doing less than what it takes to turn the problem around.

FIRST PEOPLES DISABILITY NETWORK

ADVOCATES FOR THE INTERESTS OF INDIGENOUS AUSTRALIANS WITH A DISABILITY

The First Peoples Disability Network Australia (FPDN) is a national organization, of and for Australia’s First Peoples with disability, their families and communities. It is governed by First Peoples with lived experience of disability.

The FPDN proactively engages with communities around Australia, and advocates for the interests of Indigenous Australians with a disability, both in Australia and internationally.

The FPDN works for the recognition, respect, protection and fulfilment of the human rights of First Peoples with disability and their families. The journey has been long and difficult – because of the intersection of race and disability, the organization has had to confront and overcome apathy, neglect and prejudice – both in the general community and in Indigenous communities. That struggle continues.

Since March last year the FPDN has been working in the Barkley trials site of the NDIS in the Northern Territory. This has been a lengthy process of building relationships and trust within some of Australia’s most disadvantaged communities.

Staff often travel hundreds of kilometres in a day to visit people, sometimes arriving only to learn that the community is closed due to yet another suicide in the community. Visiting one art group involves 500 km of travel each time.

Paul Calcott from the FPDN says he has gained and learned so much when advocating for those who are unable to advocate for them themselves. “We have witnessed to strength in our Elders and the passion and pride in the youth to keep culture alive against odds and conditions that many of us would not survive” said Paul concerning the monthly trips to the Northern Territory. “Our time has contributed to developing a culturally relevant and respectful resource that assists with care plans and ILC linkages that are resilience-based.”

The FPDN has recruited local community members to assist with gathering stories from people living with disability, and formed partnerships with local art centres across the region to develop artwork by local artists. The artwork will be used to develop a book that can be used as information and education resource to raise awareness of disability in community, the contribution people with disability can make to community and what a resilience-based service and support model may look like in remote communities.

The art work will also be showcased in an exhibition that will highlight disability from an Indigenous perspective.

Indigenous stock imagery used with permission.
garyradler.com
TORRES STRAIT ISLANDERS

A SEAFARING PEOPLE

Torres Strait Islanders are the Indigenous people of the Torres Strait Islands between New Guinea and mainland Australia. They are culturally akin to the coastal peoples of Papua New Guinea.

Torres Strait Islanders are regarded as being distinct from other Aboriginal peoples of the rest of Australia, and are generally referred to separately. There are also two Torres Strait Islander communities on the nearby coast of the mainland at Bamaga and Seisia.

Torres Strait Islanders were historically a seafaring people, and engaged in trade with the people of Papua New Guinea. The culture is complex, with some Australian elements, some Papuan elements, and some Austronesian elements, just like the languages. Traditionally the islanders were agriculturalists, although they supplemented food supplies through hunting and gathering.

Their more recent, post-colonization history has seen new cultural influences, most notably Christianity which caused major shifts in cultural paradigms, as well as subtler additions through the influence of Polynesian pearl-divers brought by blackbirders in the 19th Century.

Eddie Koiki Mabo is arguably the most famous Torres Strait Islander for his role in the landmark High Court of Australia decision that overturned the legal concept of terra nullius, or ‘empty land’.

LAND RIGHTS

“SETTLED” OR “CONQUERED”

In 1835, Governor Bourke proclaimed that Indigenous Australians could not sell or assign land, nor could an individual person acquire it, other than through distribution by the Crown, due to terra nullius (empty land). In 1971, Justice Blackburn ruled in a land rights case that Australia had been terra nullius before European settlement, and that there was no such thing as native title in Australian law.

Court cases in 1977, 1979, and 1982 brought by or on behalf of Aboriginal activists were rejected by the courts, but the Australian High Court left the door open as to whether Australia was “settled” or “conquered”.

Eddie Koiki Mabo was famous for his role in a landmark decision of the High Court of Australia that overturned the legal fiction of terra nullius, or ‘empty land’. In 1974, he was shocked to find that his people did not actually own Murray island, their ancestral land. Seven years later, a Land Rights Conference was held at James Cook University, where Eddie spelled out clearly his people’s land ownership and land inheritance. A ten-year legal battle eventually led to that famous court case.

Koiki’s grave site was vandalized overnight with eight spraypainted swastikas and the racist word “Abo” on his tombstone. A bronze bas-relief portrait of Eddie was also removed. Koiki’s body was reburied on Murray Island, the land he loved and fought for so hard. That night, the Islanders performed their traditional ceremony for the burial of a king, a ritual not seen on the island for eighty years.

In 1992, Eddie Mabo was posthumously awarded the Human Rights Medal in the Human Rights and Equal Opportunity Commission Awards. In 1993 The Australian voted him the 1992 Australian of the Year (not to be confused with the official Australian of the Year awards issued by the Australian Government).

In 1996, The High Court stated that native title and pastoral leases could coexist over the same area, and that native peoples could use land for hunting and performing sacred ceremonies, even without exercising rights of ownership.

The court’s ruling in Mabo has enabled some Aboriginal peoples to reclaim territory appropriated under the doctrine of terra nullius. An estimated 3,000 more agreements have been reached, in which Aboriginal peoples have regained former lands. In the Northern Territory, 40 per cent of the land and most of its coastline is now in the hands of Aboriginal peoples. However as many believe that most of the land ‘handed back’ was not seen as economically or strategically valuable.
Gabe was born prematurely at 28 weeks. Shortly after his birth Gabe experienced a cerebral haemorrhage – as time went by the extent of the effects on his development became more evident. Gabe is non-verbal and has multiple significant disabilities.

"Gabe needed intensive therapy and this became our life, and continues to be a way of life today. This was a time when it was necessary to roll back my sleeves and get on with the work required to help our son. This was also a time of profound sadness and trying to make sense of what was happening to our family", Semah said.

In the following years Gabe attended daily conductive education classes – a system of rehabilitation training for people with motor disorders, especially children. He then spent his school years in special education. Semah stated "Special school was fine although isolating and limiting – had adequate funding been available, at the time, we would have done things very differently."

In looking at the opportunities available to Gabe as he finished school Semah and Karl believed that they weren't appropriate for their son. They often ask themselves ‘Who is Gabe? What does he love? What does he want in his life? And who does he want in his life?’ The answer – Gabe is a great young man, he is inspirational, he is a foodie, a traveller, a student, an artist, he has achieved so much, and has much more to contribute.

Rather than accepting the options for Gabe given to them, Semah and Karl took an approach known as ‘Self Direction’. This allowed more scope for creativity and the ability to think about what a person wants in their life. Self-direction changed Semah's life as she was able to take control and create a life and work culture that Gabe and the family wanted. It was no longer necessary to fit into a program and this was liberating. Gabe employs all of his support workers which now permits Gabe and his family to choose who they want in their lives, it opens the pathway for people who want to work intentionally with Gabe and for respectful working relationships to be built with him. Gabe now has stable team of committed workers who know him well and support him to do what he wants to do in his life.

With Semah's help Gabe started 'Gabe's Gorgeous Goodies', a small business supplying a number of offices with snacks and refreshments. Through his work Gabe has a level of independence, has made friends, and has people who look out for him.

Gabe loves art and, for him art is a sensory experience where the creative process is perhaps more important than the artwork itself. Gabe loves the texture of thick acrylic paint and manipulating the canvas with his brush and found materials. The canvas itself isn’t immune – often folded and forced into various positions to capture the paint.

Through attending TAFE as a visual arts student, Gabe discovered the art community and built his place with the encouragement of those around him.

Recently Gabe's art has started to grab attention. His work 'Campfire' has been displayed at the State Library of Queensland, and collectors have been seeking out his work for sale. For someone who is non-verbal, art has allowed Gabe a way to express himself. It has also allowed him to connect with his Aboriginal heritage.
GOING FOR GOLD

Tracy Barrell, OAM is a dual Gold Medalist, mother of two wonderful boys, and a proud Bungdurra woman. She achieved her two medals at the 1992 Barcelona Paralympics.

Born without legs and only one arm, doctors related her disability to issues during her mothers’ pregnancy. Tracy has never really seen herself with her disability, more a “person living with a difference”. More directly Tracy comments, “it is people’s perceptions or society’s facilities that put the ‘Dis’ in My Abilities.”

Tracy was raised by her parents who from day one supported and embraced her. “I was never institutionalised. My family always allowed me to just – be me. People used to make my independence a big deal ‘she is so clever’ when it really didn’t register to me.”

She attended mainstream school which was rare and unheard of back then for children with some disabilities. “all the kids used to push me around in prams.”, she said.

While growing up her parents had constant opinions regarding her circumstances “She needs arms – she needs legs”. It was in fact in 1989 at age 14 when her mum enrolled her with the NSW Amputee Sporting Association and she commenced her sporting career.

After strong results in the NSW State Games, Tracy secured her place on the Barcelona swimming team where she went on to win gold in the 4x50 m Freestyle S1-6 and 50 m Butterfly S3-4 events. She also finished fourth in two individual events.

Despite her sporting success it unfortunately took until 2009 for Tracy to secure her first job, working for a local council. She often experienced subtle discrimination in job applications in her job searching.

Her most prestigious award is her Order of Australia Medal, awarded in 1993 for her contribution to sport. Tracy is an outstanding Australian who in a life with so many achievements, has taken her challenges in her stride and lived to maximise her ability.

Throughout her life Tracy has drawn from her experiences, positive – and the not so positive, to advocate for those with disability experiences similar to that of her own.

She has been an ambassador for a number of programs, including as an ambassador for ‘Don’t DIS my ABILITY’, a program that provides inspirational role models for people with disabilities. In 2013, she was appointed as a Living Life My Way Ambassadors and Champions by the New South Wales Government.

Tracy continues to strive as an advocate for those with similar experiences as her own.

NSW State Games, 1989
- Gold 50m Freestyle
- Gold 100m Freestyle
- Gold 50 Breaststroke
- Gold 50m Backstroke
- Gold Discuss
- Gold Javelin
- The ‘Athlete of the Meet’ Trophy

Barcelona Paralympics in 1992
- Gold 4x50m Women’s Freestyle Relay
- Gold 50m Butterfly beating the world and Paralympic record by 13 seconds.
- 4th in the finals 50m Freestyle
- 4th in the finals 50m Breaststroke
- 4th in the finals 50m Backstroke

World Championships in Malta 1994
- Bronze 50m Butterfly

Awards
- Advanced Australia Foundation
- Australia day youth citizen for Sutherland shire
- MLC Foundation

Order of Australia Medal
Also, there may not be any visible signs to alert other people that a problem exists. This often leads to misunderstanding by members of the community, who may think an inability to concentrate is due to lack of intelligence or motivation. This problem is of particular concern with children who return to the classroom after acquiring a brain injury, who may be seen as disinterested or lazy students. People who have sustained a brain injury may:

- Become easily distracted and have trouble keeping track of what is being said or done
- Have difficulty doing more than one task at a time
- Experience information overload and be slower at making sense of information.

The effects of these difficulties on people's everyday lives may affect their ability to learn and remember information, and cause them to feel frustrated with themselves and other people. They will be easily overwhelmed and confused, often leading to fatigue, headaches and dizziness.

**Causes of lack of concentration**

A lack of concentration can be caused by many factors, including:

- Fatigue and tiredness, particularly from sleep disorders or viral infections
- Pain and other physical sensations, particularly headaches but including joint, muscle or organ pain
- Illness, including short-term infections or long-term disease
- Hunger
- Dietary inadequacy, particularly B-group vitamins and iron
- Legal or recreational drugs or environmental toxins such as carbon monoxide
- Mental health conditions, particularly depression and mania
- Extremes of mood, including fear
- Injury to relevant areas of the brain.

Somebody with an acquired brain injury is at an increased risk of headaches and cognitive or physical fatigue, as well as pain arising from injury to the head or body from the incident that caused the injury. There can also be referred neurological pain, particularly in the case of whiplash. Acquired brain injury is also associated with an increased incidence of depression and other mental health issues.

**Strategies for attention & concentration**

Realise that what is happening is influenced by the brain injury. If you are supporting someone with a brain injury, provide reassurance when necessary. Generate strategies from past experience, with an awareness for what is currently working, or what has worked in the past. Be aware that what has worked in the past may no longer work due to the effects of the brain injury. Identify specific situations where particular strategies may be effective. The following strategies may be helpful:

- Reducing all possible distractions in the environment
- Take regular rest breaks, have a nap or go for a walk
- Meditation, deep breathing and other strategies for physical and mental relaxation, such as having a coffee break or talking to friends
- Plan how to approach a task with a simple step-by-step approach
- Write information down using notes, and keep them in specific places
- Use a dictaphone to tape messages that can be regularly played back
- Use a whiteboard to help organise, plan and store information
- Use ‘association’ techniques e.g. putting medication on the table with every meal
- Get into a regular daily routine which has a structure
- Aim for variety within an everyday routine
- Schedule demanding tasks when levels of energy and alertness are greatest, commonly early morning
- Eat a healthy diet and sleep well
- Use self-talk to monitor thoughts and actions
- Use a timer or electronic organiser and set yourself goals to steadily improve duration of concentration in small steps.
There is significant prevalence of disability amongst Indigenous Australians (Australian Human Rights Commission, 2015)

Indigenous Australians experience approximately twice the rate of disability as non-Indigenous Australians (Biddle, 2012);

The proportion of Indigenous people 15 years and over, reporting a disability or long-term health condition has been estimated at 37 per cent (102,900 people) (Steering Committee for the Review of Government Service Provision [SCRGSP], 2011: p. 3.6);

Published and unpublished research as well as clinical experience in Far North Queensland find that at least 10 per cent of Indigenous Australian adults have a complex neurocognitive disability and 6% have a profound or severe physical disability. In marginalized groups the prevalence is expected to be higher.

There are no accurate prevalence rates of disability amongst Indigenous Australians in Queensland. Queensland Government has estimated 2 per cent of Indigenous Queenslanders will be eligible for supports under the NDIS. This does not reflect existing published and unpublished prevalence data above.

Without accurate prevalence rates of disability amongst Indigenous Australians in Queensland many people are in danger of not being counted by the NDIS and will miss out on the supports to which they are entitled.
For people with disabilities, the transition from a childhood where you’re cared for, nurtured and perceived as “cute”, to the harsh realities of adulthood can be difficult to navigate. Leah Hobson unpacks the contradictions we face on the journey to becoming who we really are.

I’ve had this theory for a while that if you’re disabled, you take a lot longer to become whatever it is you are — whether that’s a wage slave, a queer person, an artist, or all of the above — than most people. While many others take a few cathartic years in their early to mid twenties to figure it all out, that’s the time when people with disability are grappling with multiple problems alongside the kind of identity questions that plague us all.

If you’ve spent your whole life — or even a significant chunk of it — as visibly disabled, by the time you’re in your twenties you’ve had to deal with being stared at, called names, and told you were “brave” and “special”. You’ve been ostracized through both shame and celebration. It’s no wonder you’re confused and possibly angry.

Then suddenly, when you’re no longer cute, another element rears its head. It’s possible for you to be invisible. Lots of services cut out when you’re eighteen. People who supported you at school and at home are suddenly no longer there. Agencies that may have used your image as a struggling but hopeful youth to raise funds for services (or top heavy management structures) are not interested because you are no longer part of the most fiscally viable demographic (look at a few service provider websites: the most prominent pictures will be of young children).

There are many ways to handle the sharp transition from being an object of bullying, sympathy and fundraising, to an awkward social misfit better left unseen, bundled away from the inspiring headlines about overcoming stuff. You could be burdened with a massive sense of self entitlement. You could have the world’s biggest chip on your shoulder, like I did. You might be in
complete denial, waving the ‘normal’ flag at all the ‘normal’ parades.

But whichever road you take, some things are certain. For one thing, it’s unlikely that you come out of the vastly contradictory experiences of a disabled childhood with a sense of self worth about your disability.

You’re thrust into the harsh daylight of a world that doesn’t know what to do with you, and it’s no wonder you find it hard to face yourself. Where children with disability are both celebrated and shamed without any regard for the internal schisms this creates, adults with disability also face no-win social memes.

Some of these are starkly contradictory. For example, if you’re on a pension you’re a bludger or an object of pity, but if you’re trying to work you’re clearly less efficient and able than other applicants. If you want to cure yourself, there must be something wrong with you. If you don’t want to cure yourself, there must be something wrong with you too. If you love your disability it’s weird that you’re happy about it. If you hate your disability, there’s no way you can be happy about it, ever.

Owning your capacity as a human being, your autonomy about what happens to your disabled body or mind and above all, your happiness, becomes a huge struggle. It takes energy to fight these external, invisible demons. And that’s on top of the energy it takes to live an everyday disabled life, where getting dressed might cost you an hour, or reading a book for twenty minutes might mean you can’t think straight for the next twenty. ‘Who am I?’ becomes a question that sits on the back burner while you get through one day, and then the next.

All of this takes place in a society where part of the reason that disability is so invisible is because it’s utterly uncontroversial to be pro-disability. Everyone is pro-disability, aren’t they? Nobody would want to hurt people in wheelchairs, people with guide dogs or guide dogs in wheelchairs. Would they? All you have to do to prove your pro-disability credentials is give to a charity that helps the disabled, or talk about how lovely your next door neighbour or niece is... you know, the one who is always happy because they have an intellectual disability.

In reality, our society is only pro-disability until you scratch the surface. Don’t get me wrong, there are lots of people who do lots of good things that help lots of people with disability in useful ways. But there are also schools that refuse entry to ‘difficult’ children. There are judges who let off parents who kill their disabled charges because it must be so hard. There are people who smile quietly as they drop money into the rattled tins but don’t stop to think about whether the charity they’ve just donated to puts people with disability in charge of their own lives.

And if you dare to question those things as I have here, you are unreasonably angry. And if you’re not unreasonably angry, then you must be happy, therefore everything must be okay!

Combined, all these things make it inevitable that many people with disability become cornered and tired and silenced. From then on, it’s a matter of applying common sense; people who are cornered and tired and silenced are often riddled with self doubt or self hatred. It takes time and a conscious effort of will to overcome those things.

Only then can you think about being a manager or a mother or a bisexual adventurer or a van Gogh in the making. We are losing a swathe of people who could be brilliant to sleepy decades of constricted thought. And while we as individuals with disability are disadvantaged by our lost years, so is our community. Without pride in ourselves we cannot create pride in those around us. We are too busy chasing down the invisible barriers, the things never quite said.

Like becoming that person with multiple labels, goals and ambitions, becoming a better society is a process. It’s going to take a long time and a lot of effort.

The first step is to recognise all our contradictions, traumas and mistakes.

The second step is to stop hating them.

Leah Hobson is a policy wonk, Labrador wrangler and wine drinker, usually in that order. She wrote this article in June 2014 for Ramp Up, an ABC website which featured as an online destination for news, discussion, debate and humour for everyone in Australia’s disability communities.

Indigenous stock imagery used with permission. garyradler.com

An amazing 90.77 per cent of voters ticked the yes box in 1967 when deciding on the legal status of Indigenous Australians. It is widely believed this referendum finally gave Aborigines citizenship and voting rights, but strangely enough they already had these rights!

Aborigines were given the right to be citizens in 1947, and technically the Constitution guaranteed them the right to vote. So what was it all about?

First, the referendum wanted Aborigines to be included in the census; they hadn’t been counted to that point, and as such could not be seen as ‘citizens’ in the way most Australians were. Second, the referendum sought to give the Commonwealth government the right to override State laws that were unjust or racist.

So what about voting rights? The Constitution had given Aborigines voting rights in Commonwealth elections, but only if their State granted them that right. Australia’s first Solicitor-General interpreted this as only including people who were already State voters in 1902, so both Commonwealth and State electoral rolls typically included an ‘o’ next to the names of Aborigines to deny them voting in Commonwealth elections.

In 1962 Aborigines were given the vote in Commonwealth elections irrespective of their voting rights at the state level. Late in 1962 they were given the vote in Western Australian state elections, and in 1965 they were granted that right in Queensland.
A BLACK HISTORY

Australia’s black history begins at least 40,000 to 50,000 years ago, via a land bridge from New Guinea or possibly East Timor. The land bridges sank under rising sea levels around 12,000 years ago. There is a long history of contact with the people of New Guinea, the Torres Strait Islands and Cape York. The introduction of the dingo indicates contact with South East Asia as it shares genes with the wild dogs of Thailand. There are also ‘kangaroo’ ticks on these Thai dogs!

There were mass extinctions of larger animals during an Ice Age 20,000 years ago, due to desert and sand-dune conditions. Coastal Aborigines tell stories of former lands drowned beneath the sea after this Ice Age. This isolated the Tasmanians, and probably led to the extinction of Aboriginal cultures on the Bass Strait Islands and Kangaroo Island in South Australia. In the interior, the end of the Ice Age may have led to the recolonization of the desert and semi-desert areas.

Somewhere between 250,000 and 1.25 million people lived in Australia when the first Europeans arrived. Their ability to adapt to changing environments faced its biggest challenge yet.

The Aboriginal people of Australia were not “people of an unchanging stone age” as they have been so often portrayed by European colonists; they were inventive and creative people living within cultures that were finely attuned to the rhythms and changes of the “droughts and flooding rains” that characterise the Australian environment.

The colonization of Australia has presented Indigenous Australians with many problems, and indeed many would use terms such as cultural violence for this colonization process. But to their credit, Indigenous Australians have not only survived but made significant contributions to Australia. The Prime Minister’s national apology in 2008 was a great starting point for reconciliation, and there’s a great sense of sharing this great country and working together on a better future for all Australians.

HANDS UP! Upper Limb Bootcamp

Recover function and independence after brain injury:

1. Equipment: Cutting-edge technology gives you the edge
2. Intensity: 4 hours a day, 5 days a week, 2 weeks
3. Team: Experience matters

Book your assessment today!

Advance Rehab Centre
St Leonards, Sydney
t: +61 2 9906 7777

www.archealth.com.au
MEMORY PROBLEMS ARE VERY COMMON AFTER A BRAIN INJURY, ESPECIALLY ISSUES WITH SHORT-TERM MEMORY

Typical situations include forgetting people’s names, losing a train of thought, getting lost at the shops, repeating or forgetting past conversations, misplacing objects and difficulty learning new skills. Common everyday experiences become a nightmare of confusion without strategies to manage or compensate for the effects of memory impairment.

Memory problems can occur with most brain disorders, but are particularly common with traumatic brain injury (TBI) as trauma makes it quite likely the parts of the brain responsible for memory are injured by bony protrusions inside the skull.

Lifestyle changes to improve memory
There is no ‘wonder treatment’ for memory problems, however there are many effective strategies that compensate for short-term memory impairments. As with any cognitive issues, your memory will work better if you:

- Avoid fatigue from pushing yourself too hard
- Sleep well
- Manage stress and anxiety
- Avoid alcohol, eat a healthy diet and exercise regularly.

Organize your environment
The aim is to arrange surroundings so that less reliance or demand is placed upon a person’s memory. Strategies for organizing the environment include the following:

- Keep a notepad and pen beside the phone
- Using a large notice board on the wall
- Having a special place to keep objects which go missing
- Label cupboards as a reminder of where things are kept
- Tie objects to places e.g. a pen to the phone or a key to a belt.

Short-term memory strategies
Reduce distractions as an inability to pay attention makes memory problems worse. Simply telling yourself to pay attention when you need to focus and memorize something can make a big difference.

Learn in small repeated chunks in a similar way to how we teach children. Breaking it down into repetitive manageable bits makes it much easier to remember things.

Mnemonics are techniques used for memorizing information through acronyms, short poems, stories, images or memorable phrases. A typical example is the acronym KISS for ‘keep it simple, stupid’.

External memory aids are extremely effective compensatory strategies - they aim to compensate for memory loss. Try all of the following to see which ones work best for you:

- A diary for storing and planning
- Notebooks of all sizes for various places
- Lists and checklists
- Alarm clock, wristwatch alarm and timer on your mobile phone
- Calendar or wall chart
- Voice recorder
- Electronic organizer
- Pill reminder box
- Post-it notes
- A memory book for big events, personal experiences and names.

It is important to realize that not everyone will benefit in the same way from the same tips after a traumatic brain injury. The best thing to do is to experiment with different aids until you find the one that works for you.
Indigenous Australians experience more than twice the rates of disability as that among non-Indigenous people. The Murri Disability Advisory Network is a consortium between First Peoples Disability Network, Suncare and Synapse, aiming to correct this imbalance through education, support and empowerment – not only for Indigenous Australians living with a disability, but also their communities and families.

The Murri Disability Advisory Network (Murri DAN) is a network of Indigenous Australians living with disability in Queensland. The Network helps build resilience (keeping strong) by providing opportunities for members to connect to community and culture through art and the traditional practice of yarning.

The activities of Murri DAN include:

+ Art groups across Queensland
+ Establishment of local Yarning Circles
+ Preparing Indigenous Australians for the NDIS
+ Cultural capacity building
+ Culturally relevant service delivery models

+ Expert advice to all levels of Government.

Through the advisory network, Paul Calcott has established art groups and yarning circles for communities to be able to come together for a yarn and an art class. It is a traditional way to connect with Aboriginal people. Uncle Paul has also created a respectful and culturally relevant ‘proper way’ resource. The resource was created to help Indigenous Australians with transition and planning throughout the National Disability Insurance Scheme national roll-outs.

As there is no real comparable word in Australia’s First Peoples language for “disability”, Uncle Paul thought it might be best to create a symbol using traditional art that represents our written language to depict disability.

The non-indigenous community uses the symbol of the wheelchair to represent someone with a disability – this no way reflects all forms of disability and the support needs of all individuals, but is merely a representation of an individual that has a disability who may need some additional support and consideration in their day-to-day life.

The artistic symbol most commonly used in Australia’s First Peoples language to depict a person is the U shape – this depicts the mark you leave in the earth when you sit down. A person with a disability (e.g. a missing limb) would leave a different mark in the earth to a person with both limbs. Again, this symbol does not try to indicate that only a person with a missing limb is identified as someone with a disability – its intent is to just identify someone that may need some assistance, or has to adapt to cope with everyday life.

The white dots that form the circle around the figure represent the sacred white ochre, and indicates that this person is to be treated with respect, and that their cultural and spiritual connection to country is to be acknowledged and respected.

The yellow dots around the person symbol represent life, as this is the colour of the sun and tells us that we are all living beings that have spirit and purpose regardless if we have a disability or not.

Murri DAN currently have groups in Brisbane and Maroochydore. If you are a Murri fella living with a disability or caring for someone, you are welcome to come along.

Indigenous stock imagery used with permission. garyradler.com
Suzie Kemp is a Wiradjuri woman who has been living and battling with mental illness since the age of thirteen. By the age of fourteen Suzie ended up in hospital due to the severity of the illness. Eventually she was admitted to a long-term facility for three years, followed by a six month admission into an adolescent unit. By the time she was nineteen Suzie returned home to the Sunshine Coast.

“Mum never stayed in one spot, we moved every three months so when I came home to see mum had connected with the community up here I felt like I did belong, a strong foundation in the community” said Suzie. “I learned how to manage it a lot better, I am now able to recognise when I’m getting sick and ask for help which I was never be able to do because I didn’t know how to”.

Suzie became a part of a local art and yarning group called Nandjimadji and moved in with a family friend. She then went to university through a bridging program to study social work. Suzie was invited to become a board member of the FPDN (First Peoples Disability Network) in Sydney, which led to visiting the United Nations with the FPDN Board. “It was really a rewarding opportunity something I would have never dreamed of experiencing” said Suzie.

Suzie is now the Aboriginal liaison officer at the local high school and is passionate about being able to help kids. She has also completed a counselling diploma and is now caring for her seven-year-old niece with severe disability and now lives on her own to do so.

All of the above has happened throughout the past five years and Suzie said it was from pushing herself even when she felt uncomfortable as from a young age her mother was her voice. She is so proud to have come as far as she’s come and says “Just because you have disability doesn’t mean you can’t achieve; I didn’t let me disability define who I have become.”

At the age of two Joshua Lennox suffered a severe head injury that left him having to relearn how to eat, walk and talk. Today Joshua is still left with Cerebral Palsy type impairments that affect his entire right side.

Joshua is a contemporary Indigenous artist living in his traditional land area at Mt Isa in Queensland. Joshua’s artworks are influenced by his love of colour and the freedom he feels through his expression of movement while creating art. He has paintings hanging in government institutions, corporate and private collections and tourist resorts.

Heather Castledine is a proud Aboriginal woman born into the Hooper Family and raised in Charleville on the bank of the Warrego River. Heather worked in the outback for 27 years on cattle and sheep stations, shearing sheds and earth moving camps at the back of Bourke. Whilst studying at University Heather was the carer of her ex-husband who had a mental health disability.

For the past 15 years Heather has worked for Queensland Health with Child and Youth Mental Health Service as an Indigenous Cultural Consultant to a team of Allied Health clinicians.

In addition to being a volunteer with many organizations Heather also sits on the Board of Murrigunyah (Aboriginal & Torres Strait Islanders Corporation for Women), is a Director of DV Connect (Domestic Violence service across QLD) and Youth & Family Services in Logan City, plus work as Aboriginal Elder in Logan running Cultural Workshops.
HERE’S TO YOUR HEALTH

PHYSICAL HEALTH CAN BE NEGLECTED AFTER A BRAIN INJURY – HERE IS HOW TO GET BACK ON TRACK!

Obesity and poor diet are far too common occurrences after a brain injury. Carers too, can neglect their health if the pressure of looking after their loved one with a brain injury becomes all consuming. In the long run, everyone needs to make their health a priority!

Why physical health can take a back seat

Lack of motivation can lead to no exercise, as well as the all too common fatigue. Depression will only further decrease the desire to keep fit. Shopping and cooking may seem like basic chores, but actually require complex skills of planning, prioritizing, and sequencing that may be too overwhelming. Impulsivity may lead to eating junk food as the long-term effects are disregarded. Loss of friends and social skills often lead to a very sedentary lifestyle — firmly planted in front of the television.

If the sense of smell and taste are affected, people often compensate by eating much fattier or saltier food to try to get some sense of taste. Sometimes weight loss and malnutrition can occur if the person loses interest in eating due to not being able to taste food.

Piling on the weight

Obesity is the second leading cause of preventable death after smoking, due to the risks of type 2 diabetes, heart disease, high blood pressure, stroke, and certain types of cancer. Other potential problems include gall bladder disease, liver problems, osteoarthritis, gout, breathing issues and reproductive problems in women.
Exercise
This must go hand in hand with your diet. It will be a lot harder to maintain your weight loss without increasing your exercise. Physical activity lowers your risk for high blood pressure, heart disease and diabetes beyond that produced by weight loss alone. If you are at risk for heart disease, have a chronic illness such as high blood pressure, diabetes or are obese, you should check with your doctor before adopting an exercise plan.

Make a plan
Planning and organizing are often problem areas after a brain injury. Exercise is a long-term commitment, so you will need all your planning strategies for this. Make sure you set goals that are specific, attainable and forgiving.

General goals aren’t much help. If your goal is ‘exercise more’, it doesn’t give you much to go by. Specify how much and what type of exercise you will try. Write it in your diary, post-it notes or whiteboard.

Also, make sure your goals are attainable. Don’t discourage yourself by trying to walk ten kilometres on your first try. Keep them achievable and increase your goals with time.

Lifestyle changes
Our society is geared to look for the ‘quick fix’, hence the popularity of fad diets. But research has always shown the best way to keep in shape is a combined effort of eating well and regular exercise. This is why it is crucial to change your eating and exercise habits in an achievable way. Many of us can stick to a gruelling regime for a few weeks or months. But a sensible, enjoyable change of habits will see you staying healthy in a more permanent way.

For people with a brain injury, it will be a matter of using planning and organizational strategies to make exercise and good eating a normal part of the daily routine. For carers, it may be a matter of getting enough respite care to ensure there is enough time available for exercise, shopping and cooking.

Take your first steps toward good health – your body will thank you for it!

FURTHER READING
Read our fact sheets at synapse.org.au:
- Steps to a Healthier Brain
- Rehabilitation Tips
- Alcohol and Other Drugs.

Being overweight can also cause emotional suffering. Western marketing and media continually link beauty with a slim figure, and after a brain injury, many are struggling with depression and self-confidence already. Obesity can only make it harder to feel good about oneself.

How to lose that weight
We’ve all heard of fad diets that take a few kilos off for a while. But for long-term health, it is always back to the basics – forget about short cuts! First, talk with your doctor who can help to determine how much weight you should lose, how you plan to do it, and over what period of time. Your doctor can also advise on the amount and type of exercise you need, and may agree to seeing you every few weeks to monitor how you are going. Remember, you may not need to lose as much weight for your health as you think. Your aim should be good health, not the cosmetic appeal of idealized slimness.

While exercise can assist in losing weight, recent research confirms the major key here is what we eat, and how much of it we eat.

Food
You can buy cheap calorie guide books at most news agents and find out what your food intake should be. Total fat should be less than 30% of your total calories. Reducing saturated fat is important, especially if your cholesterol is high. However, eating less fat alone won’t give you the results you want unless your total calories are reduced too.

If cakes, cookies, breads and pastas are your favourites, you may need to reduce carbohydrates as well. You may want to seek the help of a registered dietitian to help you with dietary therapy, or develop a weight management program with your doctor.

Avoid refined foods as much as possible – these are digested very quickly and you’ll feel hungry again in no time. Fruit, vegetables and food that is high in fibre takes longer to move through your system so you feel full for longer.

Alcohol
Drinks containing alcohol have often been called empty calories – alcohol contains a lot of calories but nothing useful for the body or brain. It is usually best to avoid alcohol after a brain injury, especially while your brain is still recovering.
Over 321,600 Australians are currently diagnosed with dementia, and the impacts of the disease are felt by countless more of the carers, family and friends of those affected.1 Research shows that people who have an acquired brain injury (ABI) are more likely to develop dementia in old age than the general population.2 Fortunately, there are a number of changes that can be made in our own lives to reduce our risk of dementia,3 and there are a range of community organizations dedicated to improving the quality of life of those currently living with the disease.

What is dementia?
Dementia is a broad term used to describe a range of symptoms, the most well-known of these being a gradual loss of a person’s memory.3 Other symptoms of dementia can include deterioration over time in speech, motor skills, thinking and planning, and the ability to carry out daily tasks.3 People with dementia can lose their ability to control their own behaviour and may at times be socially inappropriate or unaware.3 The disease is progressive, meaning that symptoms become worse over time, and towards the later stages of the disease people require full-time care from family members or staff in a nursing home. Dementia is a terminal disease and at present, despite the best efforts of our medical researchers, there is no cure.3

There are a number of different types of dementia, the most common being Alzheimer’s disease, and others including vascular dementia (usually related to stroke), Parkinson’s disease dementia, alcohol-related dementia, and Lewy body dementia.3 While the risk of dementia increases with age, it is not a normal or natural part of ageing.3 Although rare, people in their 50s, 40s and even 30s can be diagnosed with “younger onset” dementia.4

Reducing your risk of dementia
Researchers at the World Health Organisation (WHO) have found that a person is more likely to develop Alzheimer’s disease if they have diabetes, high blood pressure or depression.3 A person is also at greater risk if they are obese, don’t exercise regularly, if they smoke,
Indigenous Australians have been broadly referred to by many names the past two hundred years, and thankfully it is increasingly rare to hear the truly derogatory terms. As early as 1789 the term “aborigine” was used, even though this was a much older word in the English language that simply meant “first” or “earliest known”, derived from Latin for “from the beginning”.

“Aboriginal” was meant to be an adjective, but eventually came to be interchangeable with the noun so Indigenous Australians were known either as “aborigines” or “aboriginals”. Today these terms are no longer seen as appropriate and can even be regarded by some as offensive, so “Indigenous Australians” is the most common term currently, and includes Torres Strait Islanders – it is certainly less of a mouthful than “Aboriginal and Torres Strait Islander peoples” which has also been used for some time!

There are more informal terms as well, such as “Koori” used for those who live in New South Wales and Victoria, and “Murri” for those living in Queensland. These words are derived from the ancestral people whose lands roughly equated with each State or Territory of Australia.

Even the term “Indigenous Australians” may eventually change if Indigenous communities find a term they prefer – while some may find this bemusing, it is only a well-deserved consideration when the treatment of Indigenous Australians has historically been sorely lacking in any consideration.
I love children, however they don’t always love me back. This was not always the case, in fact, they used to like me. However, I now sit in a wheelchair due to a massive stroke and everyone’s reaction to me is different.

For a start, I speak very loudly, I don’t mean to, but it makes it easier to understand myself. In turn, children think I am angry and they get scared and run away. I have dyspraxia, a weakening of my vocal cords, so I sound very different to the naked ear, and can be hard to understand.

Sometimes, it is not easy to accept my fate, and I get very depressed. I was once a kindergarten teacher and children loved me. On a good day, I think they are only children not used to a loud person in a wheelchair, but on a bad day, I can get depressed, even teary.

The other day, I went to my children’s school for an open day. I explained to my daughter’s teacher I wanted to bring cupcakes for the kids as it was my way to break the ice as the children were scared of me. As soon as I said it, the teacher felt bad, then I felt bad, then the tears started. I had to flee the scene of the crime quickly so the children wouldn’t see me crying.

My psychologist often says I have to develop a thick skin, and my husband agrees, but I feel like shouting “That’s easy to say but you aren’t in my skin!” I don’t shout, as I’d only look crazy. I’m not crazy, just a little peculiar after the stroke.

My reactions are very confronting for some adults, let alone a child. For example, in conversations I won’t remember a word due to memory problems. However, all of a sudden it pops into my head and I tend to shout the word out minutes later in the conversation.

Last week, we were staying in a lovely unit on the beach with spectacular views and fantastic weather. However, I felt sad as I wanted to play cricket with my children and feel the sand on my feet and collect seashells with the kids. Instead, I was looking at them from afar.

The big problem is I’m legally blind. I can’t see very well, so I just imagined them. It’s hard to accept there are so many things you can’t do anymore.

Today, my husband kindly made pancakes for all of us. Normally, he cuts food for me, but I decided to cut my own pancake. The pancake flew off my plate, to much hysterical laughter. I joined in the laughter, and for one moment at least I felt an affinity with my children.

I shouldn’t take life so seriously, but sometimes I just do. It is my life after all.

I recently went to see my father in Spain who is unwell. My family had to employ a live-in assistant for me, but Spanish was not her first language and communication was hard. One of Khadija’s jobs was keeping me occupied so she would just plonk me in front of the TV.

It was an unpleasant trip. The time difference meant going to the toilet in the middle of the night. I tried to remember Khadija’s name, then tried to wake her from her very sound sleep. I felt all alone in the world, and thought I would actually have an accident in bed.

Khadija would treat me one way when we were alone, and much better if my family was around. I can sympathize with those babies whose working mothers leave them alone in day care, oblivious to what goes on in their children’s lives. At least, I’m a grown up, I have a voice, and I can defend myself. I told my siblings how I was being treated but our hands were tied. I was only in Spain for four weeks, there wasn’t much we could really do.

When you are in a vulnerable position you encounter all kinds of people – many are kind-hearted and some less so. People like Khadija can be insensitive, even callous, but I’m learning to deal with people in complex situations. No one should be treated as a second class citizen, regardless of having a disability or not, so I choose to surround myself with those who are kind-hearted.
STOLEN GENERATION

The Stolen Generation refers to Indigenous Australian children removed from their families by the Australian and State government agencies and church missions, under acts of their respective parliaments. The removals occurred roughly between 1869 and 1969. The numbers, and original motives behind the removals, are contested.

A NSW politician first used the word “stealing” from parents in 1915 when arguing against an Act that allowed removal of Aboriginal children without a cause. An enquiry into the stolen generation resulted in the 1997 report Bringing Them Home which further raised awareness of the issues involved.

In February 2008, Prime Minister Kevin Rudd made a formal apology:

“We apologize especially for the removal of Aboriginal and Torres Strait Islander children from their families, their communities and their country. For the pain, suffering and hurt of these Stolen Generations, their descendants and for their families left behind, we say sorry.

To the mothers and the fathers, the brothers and the sisters, for the breaking up of families and communities, we say sorry. And for the indignity and degradation thus inflicted on a proud people and a proud culture, we say sorry.”
Our vision is to empower your business through the use of Microsoft cutting edge, intelligent technology, providing you with a strategic advantage to drive success.

With our assistance you can empower your people with intelligent information management technology, such as SharePoint, Office 365 and Dynamics, to gain a strategic and highly competitive business advantage.

As your trusted technology partner, we bring a wealth of experience in providing strategic, architectural, consultative and support services to enable collaboration, integration and efficiencies.

Our team of Microsoft certified experts are capable of transforming your business to give you the edge to succeed. Specialising in the Microsoft suite, we will work with your organisation to enhance communication, information management and productivity across departments.

As one of Australia’s premium business productivity specialists we pride ourselves in providing consulting services in the areas of IT Strategy, Architecture, Project Management and Risk Management.

At Sharing Minds we take a client first approach to IT solutions as nobody understands your business better than you.

Call us today on 1300 611 359 or find out more at www.Sharing Minds.com.au