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NATIONAL CONGRESS
OF AUSTRALIA'S FIRST PEOPLES

Statement to the

House of Representatives Standing Committee on Indigenous Affairs

Alcohol harm in Aboriginal and Torres Strait Islander communities

April 2014

The National Congress of Australia's First Peoples (Congress) is the national representative body for Aboriginal and Torres Strait Islander Australians. Congress is a leader and advocate for protecting and advancing the wellbeing and empowerment of Aboriginal and Torres Strait Islander Peoples, and for securing our economic, political, cultural and environmental future.

Congress has created one of the largest networks of our Peoples in the country. Congress has more than 8,000 individual members and 175 organisational members, with these national bodies, peaks and community organisations contributing their massive membership of tens of thousands of our Peoples to the Congress movement. We acknowledge and pay respect to our ancestors, our Elders and the diversity of traditional owners across this ancient land.

1. EXECUTIVE SUMMARY

Congress' Statement draws from the expertise of its member organisations, including the National Health Leadership Forum,¹ the National Aboriginal and Torres Strait Islander Legal Services (NATSILS), Aboriginal Peak Organisations Northern Territory (APONT), and expert members of the National Indigenous Drug and Alcohol Council (NIDAC). Congress also participated in a robust consultation process for the National and Aboriginal Torres Strait Islander Health Plan, including co-hosting a dedicated Roundtable on the Drug and Alcohol issues with NIDAC in March 2013, and the principles proposed drawn from these consultations.

The serious consequences of alcohol related harm upon those affected is uncontested. It impacts on the health and quality of life for individuals, families and communities. Combatting the effects alcohol related harm will undoubtedly help Closing the Gap in health inequality and the quality of life for Aboriginal and Torres Strait Islander Peoples, as efforts towards a nuanced understanding of the issues and proportionate response is a worthy investment of time and resources.

In addressing what works in addressing the harmful use of alcohol, we start with what doesn't. Criminalising alcohol consumption in itself has been shown to be a failed strategy, merely adding to a cycle of escalating rates of incarceration. It hides specific problems in watch-houses, prisons and institutions and provides no remedy. This approach should play no future part in the alcohol policy.

¹ The National Health Leadership Forum is a national representative committee of Aboriginal and Torres Strait Islander Health Peak bodies. Residing within Chamber 1 of Congress, its members include: National Aboriginal Community Controlled Health Organisations (NACCHO); Aboriginal and Torres Strait Islander Healing Foundation; Australian Indigenous Doctors' Association; Australian Indigenous Psychologists' Association; Congress of Aboriginal and Torres Strait Islander Nurses; Indigenous Allied Health Australia; Indigenous Dentists' Association of Australia; The Lowitja Institute; National Aboriginal and Torres Strait Islander Health Workers' Association; National Association of Aboriginal and Torres Strait Islander Physiotherapists; and Torres Strait Regional Authority. Professor Ted Wilkes, Chair of NIDAC is an Expert Advisor to the NHLF.

Other forms of Government driven intervention which discriminate against Aboriginal and Torres Strait Islander Peoples are also misapplied. Such approaches perpetuate the negative stereotyping around alcohol consumption and tacit forms of racism that the broader Aboriginal and Torres Strait Islander populations are subjected to. Feeding the downward spiral around the stigmatisation of alcohol interventionist policies which are not under the control of community does more harm than good.

Instead, the harmful use of alcohol should be seen in context and for what it is – a social and health issue. As such, the way forward lies in a health and wellbeing approach based on community healing and personal rehabilitation, which addresses the historical and social factors which contribute to an unhealthy social environment and targets resources at those areas affected.

First, boundaries need to be put around the problem and where it exists. Resources can be targeted more effectively to where they are needed most if there is an objective analysis of the issues that is not influenced by prejudicial stereotyping. Along the way, strong leadership is needed to debunk the negative stereotypes and myths around alcohol consumption which pervade Australian society. Tacit racism of this type holds back efforts to achieve health equity, and there needs to be a collective effort to confront this head on.

Second, there needs to be a balanced strategic approach to the reduction of supply of alcohol, demand reduction and harm minimisation as articulated in the *The National Drug Strategy 2010-2015*.² There is strong evidence which show that supply reduction is an effective strategy, providing the breathing space needed to implement other community focused initiatives. However, supply reduction in itself will not suffice, and must be supported by a tier of strategies targeting the community and individualised care and support, each of which are substantiated by a body of evidence of their own.

Third, a cultural overlay must be applied so these strategies work in an Aboriginal and Torres Strait Islander context. There is innovative research coming from a large-scale study of international Indigenous communities³ which has conclusively proved the affirming contribution of culture as paramount to an empowered, safe and health community. Combined with the wealth of knowledge resident in our Aboriginal and Torres Strait Islander communities, culturally centred policy provides a promising prospect for success.

The fourth challenge is in implementation. The lack of systemic integration between sectors and levels of Government has historically been a problem when dealing with the complexities of alcohol-related harm and its social determinants. There needs to be a collective will to break through the systemic dysfunction for a nationally co-ordinated approach in both word and effect.

² Ministerial Council on Drug Strategy, *National Drug Strategy 2010-2015: A framework for action on alcohol, tobacco and other drugs*, (Canberra: Australian Government, 2011).

³ Michael J. Chandler, and Christopher E. Lalonde, "Cultural Continuity as a moderator of suicide risk among Canada's First Nations", in *Healing Traditions: The Mental Health of Aboriginal Peoples in Canada*, eds. Laurence J. Kirmayer, and Gail Guthrie Valaskakis. (Vancouver : UBC Press, 2009).

Aboriginal and Torres Strait Islander Peoples aspire for a bright future, and there is cause for optimism, so long as we are prepared to embrace the conclusion that preservation and restoration of culture is the pathway for positive social change. With these learnings in mind, and drawing from the knowledge and experience within our communities, Congress proposes a set of principles which should form the basis of a strategic response to harmful use of alcohol, with culture at its centre.

Aboriginal and Torres Strait Islander Peoples are the experts in the culture in their communities. There is the opportunity to empower people and communities and, through collaboration, the valuing of culture and expertise, allow us to resolve our matters our way.

Foetal Alcohol Spectrum Disorders:

With respect to the Terms of Reference addressing the prevalence and impact of Foetal Alcohol Spectrum Disorder (FASD), we note that this Inquiry follows a Senate Inquiry which reported on equivalent Terms of Reference in November 2012.⁴ The West Australian Government has conducted its own state based inquiry in September 2012⁵ and another inquiry in the Northern Territory Government has just been announced,⁶ both with comparable Terms of Reference to this Inquiry.

That the plethora of Government Inquiries has not resulted in a definitive action plan is indicative of the lack of a co-ordinated approach to addressing FASD and other environmentally acquired disabilities. Congress calls on Governments for a firm commitment to implementing a fully resourced nationally co-ordinated plan of action, to prevent a further generation of children being consigned to the ill-effects of a condition which has been widely known to exist for over a decade.

Accordingly, Congress:

- Restates its submission to the 2012 Senate Inquiry into FASD for the declaration of FASD as a disability for the purposes of accessing support services; and
- Supports a nationally co-ordinated strategy for the prevention, early detection and intervention and support for people affected by alcohol-related disability.

⁴ House of Representatives Standing Committee on Social Policy and Legal Affairs, *FASD: The Hidden Harm - Inquiry into the Prevention, Diagnosis and Management of Fetal Alcohol Spectrum Disorders*, Parliamentary paper 443/2012 (Canberra: Parliament of Australia, November, 2012).

⁵ Legislative Assembly of Western Australia, Education and Health Standing Committee, *Foetal Alcohol Spectrum Disorder: the Invisible Disability*, Report 15/2012, (Perth: Parliament of Western Australia, September, 2012).

⁶ Legislative Assembly of the Northern Territory, Select Committee on Action to Prevent Foetal Alcohol Spectrum Disorder, *Call for Submissions* (Media Release, Darwin, NT: 10 April 2014)

2. A WELLBEING MODEL FOR MITIGATING ALCOHOL HARM

Congress supports the development of a wellbeing model for the mitigation of alcohol harm in Aboriginal and Torres Strait Islander communities.

The model, which brings together the principles outlined in this Statement, is summarised below:

PRINCIPLE 1: Policies and practices to manage the effects of alcohol should be non-discriminatory.

PRINCIPLE 2: The harmful use of alcohol should be addressed as an issue of health equality (ie. not a criminal issue).

PRINCIPLE 3: Systematically address the social and systemic determinants of alcohol-related harm within a human rights framework.

PRINCIPLE 4: Preservation and restoration of Aboriginal and Torres Strait Islander Cultures are central to solutions.

PRINCIPLE 5: Community and personal healing programs which are trauma informed and culturally safe.

PRINCIPLE 6: Support the ongoing professionalisation of the alcohol support and healing workforce.

PRINCIPLE 7: Invest in education, prevention and rehabilitation, as a balance to strategies to constrain supply.

PRINCIPLE 8: Provide resources to build and translate the evidence base into effective programs drawing on the expert knowledge of Aboriginal and Torres Strait Islander Peoples and organisations.

PRINCIPLE 9: Create innovation schemes as a catalyst for research, leadership and new thinking.

PRINCIPLE 10: Declare FASD as a disability, and implement a nationally co-ordinated strategy for its prevention and support of people affected by FASD.

3. ISSUES AND PRINCIPLES

3.1 Alcohol Consumption Rates in Context

The first results of the Australian Bureau of Statistics' Australian Aboriginal and Torres Strait Islander Health Survey 2012-13 found that on a per-capita basis, standardised harmful consumption rates for Aboriginal and Torres Strait Islander people were 1.2 times that of other Australians; and long term risk rates were 1.05 times that of other Australians.⁷ By contrast, the rate of 'Abstainers' - defined as persons who consumed no alcohol in last 12 months – was 1.6 times greater than other Australians.

This data places the problem of alcohol consumption in Aboriginal and Torres Strait Islander communities in context:

- It is a serious problem which affects some Aboriginal and Torres Strait Islander people and communities, but not all; and
- Whilst the social and cultural circumstances for Aboriginal and Torres Strait Islander Peoples are unique, the harmful consumption of alcohol is of equal concern as a population health issue for other groups of Australian society which are outside the scope of this Inquiry.

3.2 The Contributing Harm of Stigmatisation and Discrimination

PRINCIPLE 1: Policies and practices to manage the effects of alcohol should be non-discriminatory.

Racial discrimination in policies, practices and discourse is a social determinant of alcohol consumption, and its prevalence is counter-productive to strategies to mitigate its harm.

A recent study of into reporting of Australian Indigenous health in the media found that over 74% of articles were negative, and over 30% of the negative articles related to alcohol.⁸ This is despite alcohol attributing to of 6% the burden of disease.⁹ This finding is indicative of the deficit model of public discourse when it comes to alcohol in Aboriginal and Torres Strait Islander communities. It feeds negative stereotyping, blame-shifting and racially-based assumptions about Aboriginal and Torres Strait Islander Peoples.

Gone unchallenged, the deficit model has led to perpetuation of discriminatory policies and practices which are counter-productive. At the policy level, legislation which criminalises alcohol use and public

⁷ Australian Bureau of Statistics, *Australian Aboriginal and Torres Strait Islander Health Survey: First Results, 2012-13 – Tables 13 and 14*. Cat. no. 4727.0.55.001 (Canberra, 2014).

⁸ Mellissa J. Stoneham, Jodie Goodman, Mike Daube, "The Portrayal of Indigenous Health in Selected Australian Media," *The International Indigenous Policy Journal* 5, no. 1 (2014), 3-5.

⁹ Australian Human Rights Commission, *Social Justice Report 2008*, (Sydney, 2009), 295. Citing: Australian Institute of Health and Welfare and Australian Bureau of Statistics, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2008*, Cat. no. 4704.0 (Canberra, 2008), 140.

drunkenness¹⁰ disproportionately affects Aboriginal and Torres Strait Islander Peoples, mainly because alcohol consumption in Aboriginal and Torres Strait Islander communities is more concentrated in publically visible places as concentrated to other Australians (although not necessarily more prevalent). This in turn contributes to the disproportionate rates of contact with the criminal justice system. These issues are covered in greater depth by NATSILS and APONT, and we refer to these organisations for their expert critique on the adverse impact of discriminatory forms of legislation.

The stigmatisation and stereotyping of alcohol also perpetuates institutional forms of racism within delivery systems providing services to people affected by alcohol and other health issues. As part of the consultations for the National Aboriginal and Torres Strait Islander Health Plan in 2012, Congress conducted a survey of its Members on their attitudes and perceptions of their health and the health system. This showed that 39.6% of respondents reported experiencing racial discrimination in their interaction with the health system.¹¹ The following narrative is indicative of experiences of institutional racism, with reference to the pervasiveness of negative stereotype around alcohol and other drugs:

"I'd been walking and went running across the road and slipped and fell arse-over-head. When I went in there to have the x-rays and I told her what happened...She turned around and said to me, you weren't charged up were you? I just thought, well that's the last thing I expected to come out of your mouth.

Next time I see her, I'm going to sit her down and say, hey, just because I'm an Aboriginal person, doesn't mean I'm charged up. You're making them assumptions and generalisations you know. I thought it was disgusting coming from a health professional".¹²

Racism has been shown to have a negative correlation with mental health issues (that is, the more experiences of racism, the poorer the mental health outcomes),¹³ and in turn poor mental health correlates with higher rates of alcohol consumption and other drugs.¹⁴ Thus, discrimination and negative stereotyping is feeding a downward spiral of harm, which must be circumvented.

¹⁰ See for example the Alcohol Protection Orders in the Northern Territory; as referenced in the NATSILS Submission to the House of Representatives Standing Committee on Indigenous Affairs, Inquiry into Alcohol Harm in Aboriginal and Torres Strait Islander Communities (April, 2014).

¹¹ National Congress of Australia's First Peoples, *Submission to the National Aboriginal and Torres Strait Islander Health Plan*, (Redfern: January 2013), 17-38.

¹² Ibid, 17.

¹³ Angeline Ferdinand, Yin Paradies, and Margaret Kelaher, *Mental Health Impacts of Racial Discrimination in Victorian Aboriginal Communities*, (Melbourne : The Lowitja Institute, 2013), 1.

¹⁴ David J. Kavanagh and Jennifer M Connolly, "Interventions for co-occurring addictive and other mental disorders (AMDs)", *Addictive Behaviours* 34, no. 10, (2009), 838-845.

Maree Teesson, Tim Slade, and Katherine Mills, "Co-morbidity in Australia: Findings of the 2007 National Survey of Mental Health and Wellbeing", *Australian and New Zealand Journal of Psychiatry* 43, (2009), 606-614.

3.3 Other Health Effects Harmful Alcohol Use

PRINCIPLE 2: The harmful use of alcohol should be addressed as an issue of health equality (ie. not a criminal issue).

Aboriginal and Torres Strait Islander Peoples have poorer health outcomes than other Australians. This is apparent in the difference in life expectancy, with Aboriginal and Torres Strait Islander males living 10.6 years and females 9.5 years less than other Australians.¹⁵ Smoking causes the highest burden of disease (12%) followed by obesity (11%), with alcohol causing 6% of the burden of disease.¹⁶

Aboriginal and Torres Strait Islander people have high rates of chronic disease, with alcohol being a major risk factor for this condition. The effects of alcohol are seen over the life course. It increases the risk of stillbirths, FASD, cognitive impairment and brain damage,¹⁷ as well as a number of diseases including cancers, liver failure and diabetes.¹⁸ There are also other outcomes of harmful alcohol use such as an increase rates of injury and injury causing death.¹⁹

The determinants of harmful alcohol use are complex and include removal from family, trauma, loss of culture, lower levels of education, lower socioeconomic status and racism.²⁰

While this does not undermine the seriousness of the issue, it is important to understand the scope of the problems in context against the culturalisation of alcohol in the media and the lack of understanding its social determinants. If the issue is to be addressed systematically, it needs to be considered a social and health issue rather than a criminal issue.

¹⁵ Australian Bureau of Statistics. *Life Tables for Aboriginal and Torres Strait Islander Australians*, November 2013, Cat. No. 3302.0. 55.003 (Canberra, 2013)

¹⁶ Australian Human Rights Commission, *Social Justice Report 2008*, 295. Citing: AIHW and ABS, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2008*, 140.

¹⁷ Sheree Cairney, Alan Clough, Muriel Jaragba, and Paul Maruff, "Cognitive Impairment in Aboriginal People with Heavy Episodic Patterns of Alcohol Use", *Society for the Study of Addiction* 102, (2007), 909.

¹⁸ Don Weatherburn, Lucy Snowball, "Is there a Cultural Explanation for Indigenous Violence? A Second Look at the NATSISS", in *Survey Analysis for Indigenous Policy in Australia: Social Science Perspectives*, eds. Boyd Hunter, Nicholas Biddle, (Canberra : ANU E Press, 2012), 51 – 52.

¹⁹ John Germov, *Second Opinion*, (Melbourne, Australia : Oxford University Press, 2009), 159.

²⁰ Australian Human Rights Commission, *Social Justice Report 2008*, 302. Citing: AIHW and ABS, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2008*, 38.

Gelaye T. Nadew "Exposure to Traumatic Events, Prevalence of Posttraumatic Stress Disorder and Alcohol Abuse in Aboriginal Communities", *Rural and Remote Health* 12, (2012), 1667 – 1679.

John Germov, *Second Opinion*, 2009, 163.

3.4 A Rights Based Approach to Tackling to Social Determinants of Health Inequality

PRINCIPLE 3: Systematically address the social and systemic determinants of alcohol-related harm within a human rights framework.

Health for Aboriginal and Torres Strait Islander Peoples focuses not only on physical health but also encompasses spiritual, cultural, emotional and social wellbeing. Health is more than the absence of sickness; it is the relationship with family and community, providing a sense of belonging and a connectedness with the environment:

“Aboriginal [and Torres Strait Islander] health means not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total well-being of their Community. It is a whole-of-life view and includes the cyclical concept of life-death-life”.²¹

Embedded in the human rights approach to health is:

- Active participation by Aboriginal and Torres Strait Islander Peoples in decision-making at all levels in accordance with the *United Nations Declaration on the Rights of Indigenous Peoples*; and
- Article 24 of the Declaration, read in conjunction with Article 12 of the *International Covenant on Economic, Social and Cultural Rights*, recognises the right of Aboriginal and Torres Strait Islander Peoples “to the highest attainable standard of physical and mental health”, or the right to health.

A healthy environment is fundamental to good health. A fully-informed human rights perspective on the problem of alcohol provides a framework for addressing the consequences of health inequality experienced by Aboriginal and Torres Strait Islander peoples, as well as the cyclical inter-connections with other issues including education, housing and homelessness, employment and interaction with the justice system. The entrenched social determinants which foster the unhealthy environment perpetuating harmful consumption of alcohol must be systematically addressed if sustained progress is to be made.

²¹ National Aboriginal Health Strategy Working Party, *A National Aboriginal Health Strategy*, (Canberra: Australian Government, 1989).

3.5 The Affirming Role of Aboriginal and Torres Strait Islander Cultures

PRINCIPLE 4: Preservation and restoration of Aboriginal and Torres Strait Islander Cultures are central to solutions.

To fully understand alcohol harm in Aboriginal and Torres Strait Islander communities, an understanding of trauma and grief as an underlying factor is required.

Congress collected an avalanche of evidence on the prevalence of trauma and its impact on community and individual wellbeing during its consultation process for the *National Aboriginal and Torres Strait Islander Health Plan*. This is illustrated in narrative evidence from one of the participants:

“A lot of our people are suffering from trauma and poverty and these are some of the reasons why a lot of our people are not well today is because they’ve either been racially abused or they’ve been – had violent issues in their lifetimes, that’s carried through their lives. That’s what I find with families and groups and the people in the community that it’s a great problem because they can’t really operate properly under normal circumstances “[B]ecause they’ve got all these trauma issues that they have to deal with but no one is helping them”.²²

Moving from trauma and grief to a positive future is the focus of research by Professors Michael Chandler and Christopher Lalonde in Canadian First Nations. This research finds that ‘cultural continuity’, or the degree to which communities had come to terms with their past and were making progress with their future goals and aspirations, is strongly related to the presence or absence of destructive and risk-taking behaviours in Aboriginal communities.²³

Looking specifically at youth suicide rates in Canadian Aboriginal communities, Chandler and Lalonde found vast disparities between communities, with negligible youth suicide rates in some communities and very high suicide rates in others. Its first conclusion is that youth suicide was not an Aboriginal-wide problem in itself, but was a problem which affected only some communities.

Chandler and Lalonde looked at the effects that poverty and isolation had on the prevalence of youth suicide. Whilst finding that suicide rates increased with poverty and isolation, they were not statistically significant variables.²⁴ They then looked at the extent to which communities had instituted a range of ‘cultural protective factors’, or practical means through which communities had taken steps to connect their own cultural heritage with how they were governed, including; community control and influence over the provision of education, health and social services; land management; and the presence of facilities to preserve and enrich their culture. It found that youth

²² Respondent to the National Congress of Australia’s First Peoples Member Survey – *Attitudes and Perceptions of Health and the Health System* (October, 2012).

²³ Michael J. Chandler, and Christopher E. Lalonde, “Cultural Continuity as a Moderator of Suicide Risk among Canada’s First Nations”. In *Healing Traditions: The Mental Health of Aboriginal Peoples in Canada*, eds. Laurence J. Kirmayer, and Gail Guthrie Valaskakis. (Vancouver : UBC Press, 2009), 221-248.

²⁴ Ibid.

suicide rates were markedly lower in communities which had instituted mechanisms of cultural continuity, compared to those that had not.²⁵ This led to their second conclusion, that cultural continuity provides the vehicle for positive social change.

Whilst this research is an international study and specifically deals with factors affecting youth suicide, it provides a well-researched logic to understand the impact of alcohol on Aboriginal and Torres Strait Islander communities. Specifically:

- (i) The harmful use of alcohol should not be seen as an Aboriginal and Torres Strait Islander-wide problem. It is a problem which disproportionately affects some communities, but not all.
- (ii) Poverty and isolation are factors of interest, but in themselves do not explain differences in incidence of harmful behaviours;
- (iii) Instead, cultural solutions provide a more definitive explanation as to what is needed to break the cycle of trauma, grief and associated behaviours such as alcohol abuse in affected communities.

Chandler and Lalonde's research into the affirming effect of cultural continuity provides a promising alternative to past strategies which have failed to curtail harmful use of alcohol in Aboriginal communities where it persists. As a large scale study across many Indigenous communities, it has many features and attributes that would readily translate to understanding alcohol consumption in Australian Aboriginal communities.

Based on this research, Congress supports the restoration and preservation of cultures as central to a direction for responding to alcohol related harm.

PRINCIPLE 5: Community and personal healing programs which are trauma informed and culturally safe.

With respect to the application of this principle into policy and practice, programs should understand the impact of unresolved trauma. These issues are inter-generational, and are not solved by incarceration or other punitive measures. Breaking the cycle will require a long term commitment to community-based healing, balanced with personal rehabilitation for individuals and families who are affected by alcohol harm.

²⁵ Ibid.

PRINCIPLE 6: Support the ongoing professionalisation of the alcohol support and healing workforce.

With respect to the application of this principle to employment and workforce development, managing the effects of alcohol within an Aboriginal and Torres Strait Islander context requires a particular skill and knowledge base. There is a large degree of knowledge distributed across the spectrum of Aboriginal and Torres Strait Islander communities.

Whilst there are national bodies such as NIDAC which are driving the ongoing professionalisation of the drug and alcohol workforce, Congress believes the sector would benefit from industry structures and professional bodies that act as a vehicle for capturing the diversity of knowledge across communities and translating to consistent standards and practices. This would include career pathways aimed at ensuring minimum entry standards across the jurisdictions.

Congress co-hosted a Drug and Alcohol Roundtable with NIDAC in March 2013, which made recommendations for up-skilling the entire health workforce on AOD issues. This included investing in the AOD workforce with specific measures such as:

- Undertaking an audit of the qualifications of the health workforce and subsequently working with AOD workers to ensure they have minimum level qualifications;
- Developing a national professional network for Alcohol and Other Drug Workers; and
- Supporting a peak body for the Aboriginal and Torres Strait Islander AOD agencies.

3.6 Prevention is better than a cure

PRINCIPLE 7: Invest in education, prevention and rehabilitation, as a balance to strategies which constrain supply.

Research has identified that alcohol is a key social-economic factor shown to increase the risk of Aboriginal and Torres Strait Islander people being charged or imprisoned.²⁶ Compounding this over representation are mandatory sentencing laws that remove the ability for the judiciary to consider circumstances.²⁷ Recent evidence shows that Aboriginal and Torres Strait Islander adults are incarcerated at 14 times the rate of non-Aboriginal and Torres islander adults, and Aboriginal and

²⁶ Don Weatherburn, Lucy Snowball, and Boyd Hunter, "The Economic and Social Factors Underpinning Indigenous Contact with the Justice System: results from the 2002 NATSISS survey", *Contemporary Issues in Crime and Justice*, no. 104. (2006), 2.

²⁷ Anthony Pyne, "Ten Proposals to Reduce Indigenous Over-Representation in Northern Territory Prisons", *Australian Indigenous Law Review* 15, no. 2 (2012), 2-3.

Torres Strait Islander young people are almost 24 times more likely to be in youth detention than non-Aboriginal and islander young people.²⁸

The custodial-based corrections policy is expensive both in social and economic terms, in 2010-11 alone, prison expenditure totalled \$3 billion, equating to \$315 per prisoner per day.²⁹ As prison expenditure is increasing in real terms at a rate of 1.9% per annum (i.e. above the rate of inflation), there are real questions as to the economic sustainability of pursuing current corrections policy focused on the building and filling prisons and other infrastructure intensive institutional responses.

By contrast, evidence supports the proposition that prevention, early intervention and diversion of alcohol related crime offenders deliver significantly higher economic and social outcomes. An evaluation of an alcohol diversion program in Queensland in 2010 found that there were reductions in seriousness and frequency of offending, in all offences, including alcohol offences.³⁰ Other research commissioned by NIDAC affirms the health, social and economic benefits of residential-based drug and alcohol rehabilitation in contrast to custodial sentencing. Their analysis found that rehabilitation services resulted in significant financial savings, lower mortality rates and increased quality of life, including:

- Reduced rates of recidivism;
- Mental health service usage;
- Lower rates of relapse;
- Improvements in premature death; and economic benefits resulting from using residential care instead of prison of \$204,217 per offender (comprising \$111,458 in financial benefits and \$92,759 in quantified benefits through improvements to quality of life and longevity).³¹

With the evidence indicating that superior and social and economic benefits are achieved through prevention and rehabilitation, these should be favoured in policy, program and investment decisions.

²⁸ Australian Institute of Health and Welfare, *Juvenile Justice in Australian 2010-11*, 2012, Cat. no. JUV 10 (Canberra, 2012), 7.

²⁹ National Indigenous Drug and Alcohol Committee, Australian National Council on Drugs, *An economic analysis for Aboriginal and Torres Strait Islander Offenders: Prison vs Residential Treatment*, (Canberra, 2013), vii.

³⁰ *Ibid*, 39.

³¹ *Ibid*, 63.

3.7 Evidence Informed Practice and the Value of Community Knowledge

PRINCIPLE 8: Provide resources to build and translate the evidence base into effective programs drawing on the expert knowledge of Aboriginal and Torres Strait Islander Peoples and organisations.

Congress supports accountability for publicly funded programs. Within an evidence-informed approach to policy and programs there needs to be an understanding and agreement as to what evidence is, where it exists, and how to utilise it effectively.

There is expertise within and across our communities which is a valuable and often under-utilised resource. Many programs and initiatives are implemented in communities which would not have sufficient sample size to conduct a statistically significant evaluation study, yet provide valuable insights into how proven program design principles can be adapted to meet specific local needs. The skill is in piecing together the evidence from diverse sources and translating the learnings in a way that has national benefit.

The Fitzroy Valley Project to address the prevalence of FASD in a West Australian Aboriginal community provides an example on the value of community expertise and knowledge and why it should be held in highly regard.³² It was the Aboriginal women in the Fitzroy Valley community who first became concerned about the high rates of alcohol use in pregnancy and its possible impact on child development. These concerns were raised in community meetings as early as in 2004. After years of advocacy, restrictions on the supply of alcohol were put in place. A research partnership between Aboriginal health organisations and research institutions commenced in 2010 to conduct a FASD prevalence study. As a supported process, this research partnership is now generating knowledge which transcends the community, such as the development of a standard diagnostic tool for FASD which can be used nationally.³³

PRINCIPLE 9: Create innovation schemes as a catalyst for research, leadership and new thinking.

The Fitzroy Valley case study highlights the opportunities for innovation which can be derived from community knowledge. However, existing bureaucratic processes are slow in responding to emerging needs and supporting innovative solutions. There is potential for greater gain by accelerating the process of research, program development and knowledge sharing through responsive mechanisms and support schemes which encourage leadership and innovation.

³² See Australian Human Rights Commission *Social Justice Report* (2010), Section 3.3 for a detailed account of the early stage development of the Fitzroy Valley Project.

³³ James P Fitzpatrick, Jane Latimer, Manuela Ferreira, Alexandra LC Martiniuk, Elizabeth Peadon, Maureen Carter, June Oscar, Emily Carter, Meredith Kefford, Rhonda Shandley, Harry Yungabun, and Elizabeth J Elliott. "Development of a Reliable Questionnaire to Assist in the Diagnosis of Fetal Alcohol Spectrum Disorders (FASD)," *BMC Pediatrics* 13, no. 33 (2013). <http://www.biomedcentral.com/1471-2431/13/33>.

3.8 Foetal Alcohol Spectrum Disorders (FASD) as a Disability

PRINCIPLE 10: Declare FASD as a disability, and implement a nationally co-ordinated strategy for its prevention and support of people affected by FASD.

Congress reiterates its submission to the House of Representatives Standing Committee on Social Policy and Legal Affairs Inquiry into Foetal Alcohol Spectrum Disorder August 2012, supporting the inclusion of FASD as an officially recognised disability.³⁴

The United Nations *International Convention on the Rights of Persons With Disabilities*, to which Australia is a signatory, establishes the internationally accepted standard for assessing whether conditions a disability, and the framework for applying domestic disability policy. It adopts a social model of disability, defining disability as:

“those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.”³⁵

The effects FASD on early childhood development are well established by medical and scientific literature³⁶.

The research widely acknowledges that FASD is a life-long condition, which impacts on access to education, justice and services which in turn affects inclusiveness in society for those people affected.³⁷ FASD meets the internationally accepted definition of a disability established by the *International Convention on the Rights of Persons with Disabilities*, and as a signatory, Australia will be in compliance with its human rights obligations under the Convention by formally recognising it as a disability.

The implications for those affected by alcohol are more practical. The National Disability Insurance Scheme has been established to provide a social model of care providing service to the individual, facilitating access to the fundamental rights of education, employment, housing and a healthy wellbeing. Failing to recognise FASD as a disability for these purposes would deny those children access to vital services to assist them in overcoming the barriers they face. Instead, without the social support provided as a disability, they face a potential life trajectory of dis-engagement with the education sector, unemployment, and interactions with police and the justice sector.³⁸

³⁴ National Congress of Australia's First Peoples, *Statement to the Inquiry into Foetal Alcohol Spectrum Disorder*, (Redfern, August 2012).

³⁵ United Nations, *Convention on the Rights of Persons with Disabilities*, opened for signature 13 December 2006, 2515 UNTS 3 (entered into force on 3 May 2008). Ratified by Australia on 17 July 2008.

³⁶ Hans-Ludwig Spohr, Judith Willms, and Hans-Christoph Steinhausen, “Fetal Alcohol Spectrum Disorders in Young Adulthood,” *Journal of Pediatrics* 150, no. 2 (2007).

³⁷ Ann P. Streissguth, Fred I. Bookstein, Helen M. Barr, Paul D. Sampson, Kieran O'Malley, and Julia Kogan Young, “Risk Factors for Adverse Life Outcomes in Fetal Alcohol Syndrome and Fetal Alcohol Effects,” *Journal of Developmental and Behavioral Pediatrics* 25, no. 4 (2004).

³⁸ Don Weatherburn, Lucy Snowball and Boyd Hunter, “The Economic and Social Factors Underpinning Indigenous Contact with the Justice System: results from the 2002 NATSISS survey”, 3.

Acknowledging FASD in the eligible list of recognised disabilities would also enable carers to access a Carers Allowance as financial support to the person with FASD.

3.9 A Nationally Co-ordinated Approach to the Prevention, Diagnosis and Support for People Affected by FASD

This Inquiry follows previous Inquiries which have addressed FASD with comparable terms of reference. In November 2012, the House of Representatives Standing Committee on Social Policy and Legal Affairs tabled its report into its Inquiry into FASD.³⁹ The Committee's 19 recommendations included:

- A Commonwealth Government *National Plan of Action* for the prevention, diagnosis and management of FASD (Recommendation 1); and
- That the Commonwealth Government recognise that people with FASD have, amongst other disabilities, a cognitive impairment and therefore amend the eligibility criteria to enable access to support services and diversionary laws (Recommendation 19).

The Senate Standing Committee's Inquiry was itself preceded by tabling of the House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs tabled their report, *Doing Time – Time for Doing: Indigenous youth in the criminal justice system*. The Committee received evidence about alcohol and substance abuse, alcohol reforms and the incidence of FASD in Indigenous communities, and recommended that the Commonwealth Government take action on addressing the consequences of alcohol harm.⁴⁰ At the State and Territory Level, the Education and Health Standing Committee of the Western Australian Government reported on *Foetal Alcohol Spectrum Disorder: the invisible disability* (September 2012)⁴¹, and the Select Committee on Action to Prevent Foetal Alcohol Spectrum Disorder in Northern Territory Government recently called for submissions to its Inquiry to better understand the nature and the size of the problem of FASD.⁴²

The succession of Government Inquiries at Commonwealth and State level into the prevalence and impact of FASD without providing any direction on how to tackle the issue is indicative of a lack of co-ordination that is wasting resources.

³⁹ House of Representatives Standing Committee on Social Policy and Legal Affairs, *FASD: The Hidden Harm - Inquiry into the Prevention, Diagnosis and Management of Fetal Alcohol Spectrum Disorders*, Parliamentary paper 443/2012 (Canberra : Parliament of Australia, November, 2012).

⁴⁰ House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs, *Doing Time - Time for Doing: Indigenous Youth in the Criminal Justice System*, Parliamentary paper 145/2011 (Canberra : Parliament of Australia, June, 2011).

⁴¹ Legislative Assembly of Western Australia, Education and Health Standing Committee, *Foetal Alcohol Spectrum Disorder: the Invisible Disability*, Report 15/2012, (Perth : Parliament of Western Australia, September, 2012).

⁴² Legislative Assembly of the Northern Territory, Select Committee on Action to Prevent Foetal Alcohol Spectrum Disorder, *Call for Submissions*, 10 April, 2014.

This Inquiry must be a catalyst for change. Congress supports calls for a Nationally Coordinated Plan of Action for the prevention, diagnosis and support for people affected by FASD and related disorders. It must seek to divert resources from further inquiries into the scope of the problem and into programs which address the problem. Consistent with the principle outlined in this Statement, the National Action Plan should be cognisant of the social and cultural context in Aboriginal and Torres Strait Islander communities.

A National FASD Action Plan should be developed under the guidance of Aboriginal and Torres Strait Islander Peoples and their representative bodies with expertise in the field. At a minimum, the National Action Plan should emphasise education and awareness as a tool for prevention, and address the issue in a way which is sensitive to the stigmatisation of 'blame' and the labelling of FASD, which is starting to emerge as a barrier to people accessing the support services they need.

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