# 11 Safe and supportive communities

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| Strategic areas for action |
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| Governance, leadership and culture |  | Early child development |  | Education and training |  | Healthy lives |  | Economic participation |  | Home environment |  | Safe and supportive communities |
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| 11.1 Alcohol consumption and harm11.2 Drug and other substance use and harm11.3 Juvenile diversions | 11.4 Repeat offending11.5 Community functioning |
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Safe and supportive families and communities provide a resilient, caring and protective environment, promoting a range of positive outcomes. However, problems in families and communities can contribute to disrupted social relationships, social alienation, alcohol and drug misuse and family violence.

The indicators in this strategic area for action focus on the key factors that contribute to safe and supportive communities:

* alcohol consumption and harm (section 11.1) — excessive alcohol consumption increases an individual’s risk of death, disease and injury. Alcohol also contributes to family and community related problems, such as child abuse and neglect, work or financial problems, family breakdown, and violence and crime
* drug and other substance use and harm (section 11.2) — drug and other substance misuse contributes to illness and disease, accident and injury, violence and crime, family and social disruption, and workplace problems
* juvenile diversions (section 11.3) — diversionary alternatives in the juvenile justice system are aimed at reducing reoffending and the negative labelling and stigmatisation associated with formal contact with the criminal justice system
* repeat offending (section 11.4) — it is important that those who have had contact with the criminal justice system have the opportunity to integrate back into the community and lead positive and productive lives
* community functioning (section 11.5) — individual wellbeing is influenced by community wellbeing, and vice versa. Stronger community functioning, as defined by Aboriginal and Torres Strait Islander Australians themselves, will improve social, emotional and economic wellbeing.

Safe and supportive communities can have a positive influence across all the COAG targets and headline indicators. Three headline indicators are particularly associated with breakdown in family and community relationships:

* substantiated child abuse and neglect (section 4.11)
* family and community violence (section 4.12)
* imprisonment and juvenile detention (section 4.13).

Outcomes in the safe and supportive communities strategic area can be affected by outcomes in other strategic areas for action, or can influence outcomes in other areas:

* governance, leadership and culture (chapter 5)
* early child development (chapter 6)
* education and training (chapter 7)
* healthy lives (chapter 8)
* economic participation (chapter 9)
* home environment (chapter 10).

Attachment tables for this chapter are identified in references throughout this chapter by an ‘A’ suffix (for example, table 11A.1.1). These tables can be found on the web page (www.pc.gov.au/oid2016).

## 11.1 Alcohol consumption and harm[[1]](#footnote-1)

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| Box 11.1.1 Key messages |
| * Alcohol is a major risk factor affecting the wellbeing of Aboriginal and Torres Strait Islander Australians, their families and the broader community.
* Based on self‑report by Aboriginal and Torres Strait Islander Australians aged 15 years and over, in 2014‑15:
* 39.9 per cent reported not consuming alcohol in the previous 12 months (or drank one day a year or less), an increase from 2008 (35.6 per cent) but similar to 2002 (38.3 per cent) (table 11A.1.1)
* 15.2 per cent reported exceeding lifetime alcohol risk guidelines, a decrease from 19.4 per cent in 2008 and similar to 17.3 per cent in 2002 (figure 11.1.1)
* 30.8 per cent reported exceeding single occasion risk guidelines in the two weeks prior to interview, lower than 38.2 per cent in 2008 and 35.1 per cent in 2002 (table 11A.1.1).
* Between 2004‑05 and 2014‑15, after adjusting for differences in population age structures, for NSW, Victoria, Queensland, WA, SA and the NT combined, the acute intoxication hospitalisation rate for Aboriginal and Torres Strait Islander Australians increased from 5.7 to 11.4 times the rate for other Australians (table 11A.1.10).
* For 2010–2014, after adjusting for differences in population age structures, for NSW, Queensland, WA, SA and the NT combined, the alcohol‑induced death rate for Aboriginal and Torres Strait Islander Australians was 5 times the rate for non‑Indigenous Australians (table 11A.1.15).

In 2013‑14, the proportion of Aboriginal and Torres Strait Islander homicides involving both the victim and offender having consumed alcohol at the time of the offence (66.7 per cent — 16 out of 24) was higher than the proportion for non‑Indigenous homicides (16.3 per cent — 23 out of 141) (table 11A.1.16). |
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| Box 11.1.2 Measures of alcohol consumption and harm |
| There is one main measure for this indicator (aligned with the associated National Indigenous Reform Agreement [NIRA] indicator). *Levels of risky alcohol consumption* isdefined as the proportion of Australians aged 18 years and over who consume alcohol at risky/high risk levels (more than two standard drinks on any day, based on the concept of ‘Lifetime risk of alcohol harm’ in the National Health and Medical Research Council [NHMRC] 2009 guidelines).The most recent available data are from the ABS National Aboriginal and Torres Strait Islander Social Survey (NATSISS) for 2014‑15 (all jurisdictions; remoteness; sex; age). Comparable data are not available for non‑Indigenous Australians and therefore the NIRA report does not use NATSISS data to report on alcohol consumption.  |
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| Box 11.1.2 (continued) |
| The NATSISS data in this report focus on people aged 15 years and over, consistent with the ABS NATSISS publication and the Australian Health Ministers’ Advisory Council Aboriginal and Torres Strait Islander Health Performance Framework report.Three supplementary measures are also reported:* Alcohol related hospitalisations (all jurisdictions; sex; remoteness)
* Alcohol induced deaths (NSW, Queensland, WA, SA and the NT; sex)
* Alcohol involvement in homicides (national).
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Alcohol is one of the major risk factors affecting the wellbeing of Aboriginal and Torres Strait Islander Australians (COAG 2012), with harmful alcohol consumption responsible for a considerable burden of death, disease and injury (AIHW 2012; NHMRC 2009). Years of alcohol misuse can lead to chronic diseases, and increase the risk of heart, stroke and vascular diseases, liver cirrhosis, several types of cancers and cognitive impairment (Gao, Ogeil and Lloyd 2014; NHMRC 2009). It also contributes to disability and death indirectly, through accidents, violence, suicide and homicide (AIHW 2014; Calabria et al. 2010). See section 4.9 for information on disability and chronic disease, and section 8.8 for information on suicide and self‑harm.

Alcohol‑related harm is not limited to drinkers but also affects families, bystanders and the broader community (Intergovernmental Committee on Drugs 2014; NHMRC 2009). Excessive alcohol consumption contributes to workplace problems, child abuse and neglect, financial problems (poverty), family breakdown, interpersonal/domestic violence, and crime (AIHW 2014; Laslett et al. 2010; Wild and Anderson 2007). Alcohol is a significant contributor to violence in Aboriginal and Torres Strait Islander communities (Livingston 2011; Meulerners et al. 2010; Wundersitz 2010). Substantiated child abuse and neglect is covered under section 4.11. Family and community violence is covered under section 4.12.

The National Health and Medical Research Council (NHMRC) guidelines advise not drinking as the safest option for women who are pregnant or planning a pregnancy (NHMRC 2009). Alcohol consumption during pregnancy may cause physical and neurocognitive disorders termed ‘fetal alcohol spectrum disorders’ (Fitzpatrick et al. 2012; O’Leary et al. 2007). Alcohol consumption during pregnancy, and associated impacts, is discussed in section 6.2.

### Levels of risky alcohol consumption

In 2014‑15, 39.9 per cent of Aboriginal and Torres Strait Islander Australians aged 15 years and over reported not consuming any alcohol in the previous 12 months (or drank one day a year or less). This was an increase from 2008 (35.6 per cent) but similar to 2002 (38.3 per cent) (table 11A.1.1). A higher proportion of Aboriginal and Torres Strait Islander Australians aged 55 years and over (53.6 per cent) reported not consuming any alcohol in the previous 12 months compared to other adult age groups (table 11A.1.3).

#### Exceeding lifetime risk guidelines

The 2009 NHMRC guidelines advise that, for healthy men and women, drinking no more than two standard drinks on any day reduces the lifetime risk of harm from alcohol related disease or injury.

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| Figure 11.1.1 Exceeding lifetime risk guidelines in the previous 12 months**a, b** |
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| Figure 11.1.1 Exceeding lifetime risk guidelines in the previous 12 months  More details can be found within the text surrounding this image.  |

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| a Data exclude not stated responses. b Data for the 15–17 year old age cohort should be used with caution and are not separately reported in this chart.  |
| *Sources*: ABS (unpublished) National Aboriginal and Torres Strait Islander Social Survey2002, 2008 and 2014‑15; table 11A.1.3. |
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Nationally in 2014‑15, the proportion of Aboriginal and Torres Strait Islander Australians aged 15 years and over who reported exceeding lifetime risk guidelines:

* was 15.2 per cent, a decrease from 19.4 per cent in 2008 and similar to 17.3 per cent in 2002
* ranged from 11.4 per cent among those aged ‘55 years and over’ to 21.2 per cent among ‘35–44 year olds’
* decreased for those aged 18–24 years from 18.6 per cent in 2002 to 15.2 per cent, whilst other adult age groups did not change significantly over the same period (figure 11.1.1).

Among Aboriginal and Torres Strait Islander Australians in 2014‑15, reported rates of alcohol consumption exceeding lifetime risk guidelines were:

* greater for males (23.1 per cent) than for females (8.1 per cent) — both having decreased since 2008 (from 29.7 and 10.2 per cent, respectively) (table 11A.1.1)
* higher in remote areas (21.1 per cent) than other areas, which ranged from 12.0 per cent in major cities to 16.2 per cent in very remote areas (table 11A.1.7).

#### Single occasion risk

The NHMRC 2009 guidelines advise that, for healthy men and women, drinking no more than four standard drinks on a single occasion reduces the risk of alcohol‑related injury arising from that occasion.

Nationally in 2014‑15, 30.8 per cent of Aboriginal and Torres Strait Islander Australians reported exceeding the single occasion risk guidelines in the previous two weeks, lower than those reported in 2008 (38.2 per cent) and 2002 (35.1 per cent). A greater proportion of males (40.8 per cent) than females (21.7 per cent) reported exceeding single occasion risk guidelines in the previous two weeks (table 11A.1.1).

The proportion of Aboriginal and Torres Strait Islander Australians aged 15 years and over exceeding single occasion risk was highest in remote areas (39.4 per cent)[[2]](#footnote-2) (table 11A.1.7).

In 2014‑15, a higher proportion of Aboriginal and Torres Strait Islander Australians in non‑remote areas (69.6 per cent) reported that alcohol was not a neighbourhood/community problem than in remote areas (36.2 per cent) (section 11.5, table 11A.5.3). Alcohol risk level data by State and Territory, age and non‑remote/remote areas are available in tables 11A.1.2–7.

### Alcohol related hospitalisations

Data on hospitalisations related to alcohol use are from the AIHW National Hospital Morbidity Database. These data only cover illnesses and conditions directly attributable to alcohol consumption that result in admission to a hospital. They do not include conditions where alcohol may be a contributing factor but where the link is not direct and immediate (various cancers, liver diseases, and chronic gastritis, some suicides and strokes).

For this report, hospitalisations data are presented for the non‑Indigenous population from 2012‑13 onwards (for prior years the data are presented for ‘other’ which includes non‑Indigenous Australians and those for whom Indigenous status is unknown or not stated). Prior to 2010‑11, six jurisdictions (NSW, Victoria, Queensland, WA, SA and the NT) were considered to have acceptable quality of Aboriginal and Torres Strait Islander identification in hospitalisation data. The attachment tables for this report include hospitalisations data for all jurisdictions for 2012‑13 to 2014‑15 for Aboriginal and Torres Strait Islander and non‑Indigenous Australians, as well as data for the six jurisdictions for 2004‑05 to 2014‑15 for Aboriginal and Torres Strait Islander and other Australians.

Nationally in 2014‑15, the alcohol‑related hospitalisation rate for Aboriginal and Torres Strait Islander Australians was 727.8 per 100 000 population (table 11A.1.8). Rates were highest in remote areas (1154.1 per 100 000) and lowest in major cities (566.7 per 100 000) (table 11A.1.11). After adjusting for differences in population age structures, the rate of alcohol‑related hospitalisations for Aboriginal and Torres Strait Islander males was four times the rate for non‑Indigenous males and the rate for Aboriginal and Torres Strait Islander females was over three times the rate for non‑Indigenous females (table 11A.1.9).

In 2014‑15, alcohol‑related hospitalisations for Aboriginal and Torres Strait Islander Australians were highest for acute intoxication, around 11 times the rate for non‑Indigenous Australians (table 11A.1.9). The hospitalisation rate for acute intoxication for Aboriginal and Torres Strait Islander Australians in remote and very remote areas (865.4 per 100 000) was more than three times the rate in major cities (246.6 per 100 000) (table 11A.1.11).

Between 2004‑05 and 2014‑15, after adjusting for differences in population age structures, for NSW, Victoria, Queensland, WA, SA and the NT combined, the acute intoxication hospitalisation rate for Aboriginal and Torres Strait Islander Australians increased from 5.7 to 11.4 times the rate for other Australians (table 11A.1.10).

Data on hospitalisations related to alcohol use by State and Territory are available in tables 11A.1.13–14.

### Alcohol induced deaths

Alcohol is responsible for a considerable burden of death in Australia (NHMRC 2009). Mortality data disaggregated by Indigenous status are available for NSW, Queensland, WA, SA and the NT, as these jurisdictions have sufficient levels of Aboriginal and Torres Strait Islander identification and numbers of deaths to support analysis.

For the period 2010–2014, after adjusting for differences in population age structures, for NSW, Queensland, WA, SA and the NT combined, the alcohol‑induced death rate for Aboriginal and Torres Strait Islander Australians was 5 times the rate for non‑Indigenous Australians (table 11A.1.15).

The majority (around two‑thirds) of alcoholic‑related deaths for both Aboriginal and Torres Strait Islander and non‑Indigenous Australians are from alcoholic liver disease. The rate of deaths from alcoholic liver disease for Aboriginal and Torres Strait Islander females was 7 times the rate for non‑Indigenous females, and for Aboriginal and Torres Strait Islander males it was 4 times the rate for non‑Indigenous males (table 11A.1.15).

### Alcohol involvement in homicides

The relationship between excessive alcohol consumption, violence, crime and injury is well documented (see section 4.12; Bryant and Willis 2008; Bryant 2009; HREOC 2006; Livingston 2011; Meulerners et al. 2010; Snowball and Weatherburn 2006; Wundersitz 2010). The latest data on alcohol related homicides are for 2013‑14, from the Australian Institute of Criminology National Homicide Monitoring Program.

In 2013‑14, there were 237 homicide incidents resulting in 247 victims of homicide (section 4.12, tables 4A.12.29 and 4A.12.31). Of the 237 incidents, the Indigenous status of victims and offenders were known in 175 incidents. Among these, 24 homicide incidents involved Aboriginal and Torres Strait Islander Australians as both victims and offenders. In 16 of these incidents (66.7 per cent), both the victim and offender had consumed alcohol at the time of the offence. In comparison, of the 141 homicide incidents involving only non‑Indigenous victims and offenders, 23 (16.3 per cent) involved both the victim and offender consuming alcohol (table 11A.1.16).

The number of Aboriginal and Torres Strait Islander homicide incidents fluctuated over the period 1999–2000 to 2013‑14. However, the majority of Aboriginal and Torres Strait Islander homicide incidents each year involved alcohol consumption (table 11A.1.16).

### Things that work

There is no single solution to the harms associated with alcohol misuse. Moreover, there is a paucity of high quality formal evaluations of interventions of Aboriginal and Torres Strait Islander‑specific alcohol misuse (Gray and Wilkes 2010; Wilson et al. 2010). Aboriginal and Torres Strait Islander Australians are aware of the devastating impact of alcohol on their communities and many interventions to address alcohol misuse have been initiated by Aboriginal and Torres Strait Islander Australians themselves. For example, the **Fitzroy Crossing Liquor Restriction** (WA) was highlighted as a case study in previous editions of this report. Another example is the Aboriginal and Torres Strait Islander community in Norseman (WA), where the community became increasingly concerned that heavy alcohol consumption was the main cause of chronic health problems. The Aboriginal and Torres Strait Islander community in Norseman is distributed throughout the township, so the option of declaring themselves dry was not available. However, recognition that certain beverages were particularly associated with heavy drinking led the community to propose restricting the sale of these products (Schineanu, Velander and Saggers 2010).

An independent mixed method long‑term evaluation of the **Norseman Voluntary Liquor Agreement** found there was a significant decrease in rates of burglary, domestic violence and assaults by Aboriginal and Torres Strait Islander people between the period before the initial restriction (March 2008) and the period after the additional restriction (August 2009). While the total consumption of all recorded beverages, as measured by volume of pure alcohol, did not decline at any point, there were changes in purchasing preferences (Midford, McKenzie and Mayhead 2016). There was agreement that the restrictions should remain in place, but reconsidered in light of changing purchase preferences. The evaluation also recommended a greater focus on social determinants that underpin problematic drinking, particularly education, job skills and employment opportunities (Midford, McKenzie and Mayhead 2016).

### Future directions in data

Data on alcohol use are derived from surveys which are limited by sampling, survey administration and questionnaire design and may underestimate actual consumption (Gray and Wilkes 2010; Lee et al. 2014). Results of previous ABS surveys and administrative data collections on use of alcohol and illegal drugs suggest a tendency for respondents to underreport actual consumption levels (ABS 2016), and whilst national surveys may provide a broad indication of the prevalence of alcohol use, any significant regional variation is concealed. Reliable population estimates of alcohol use are fundamental to inform funding and the design of initiatives to prevent and treat harmful use (Lee et al. 2014).

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## **11.2 Drug and other substance use and harm**[[3]](#footnote-3)

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| Box 11.2.1 Key messages |
| * In 2014‑15, around two‑thirds (68.6 per cent) of Aboriginal and Torres Strait Islander adults reported not having used drugs in the previous 12 months (table 11A.2.1).
* The proportion of Aboriginal and Torres Strait Islander adults reporting illicit substance use in the previous 12 months increased from around 23 per cent in all earlier survey periods (2002, 2008 and 2012‑13) to 30.8 per cent in 2014‑15 (table 11A.2.1). This increase was driven by higher reported non-medical use of ‘analgesics and sedatives’, by both males (11.3 per cent) and females (14.5 per cent) (figure 11.2.1) and in non‑remote areas (table 11A.2.3).
* Between 2004‑05 and 2014‑15, after adjusting for differences in population age structures, for NSW, Victoria, Queensland, WA, SA and the NT combined, rates of hospitalisation for Aboriginal and Torres Strait Islander Australians increased from 1.4 to 2.3 times the rate for other Australians for drug‑related poisoning, and increased from 2.7 to 3.1 times the rate for drug‑related mental/behavioural disorders (table 11A.2.10).
* For 2010–2014, after adjusting for differences in population age structures, for NSW, Queensland, WA, SA and the NT combined, the drug‑induced death rate for Aboriginal and Torres Strait Islander Australians was 1.9 times the rate for non‑Indigenous Australians (table 11A.2.14).
* In 2013‑14, a smaller proportion of Aboriginal and Torres Strait Islander homicides had drug involvement (7 out of 24) than non‑Indigenous homicides (53 out of 141) (table 11A.2.15).
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| Box 11.2.2 Measures of drug and other substance use and harm |
| There is one main measure for this indicator. *Substance use* is defined as the proportion of people aged 18 years and over who reported using illicit substances or misusing licit substances in the previous 12 months. Data are sourced from the ABS Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS)/National Aboriginal and Torres Strait Islander Social Survey (NATSISS), with the most recent available data for 2014‑15 from the NATSISS (all jurisdictions; sex; age). Data are not available for non‑Indigenous Australians or (for the 2004‑05 survey) remote areas. Three supplementary measures are also reported by Indigenous status:* Drug related hospitalisations (all jurisdictions; sex; remoteness)
* Drug induced deaths (NSW, Queensland, WA, SA and the NT; sex)
* Drug involvement in homicides (national).
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The misuse of legal drugs has major negative effects on individuals, families and communities (see section 11.1 ‘Alcohol consumption and harm’ and section 8.4 ‘Tobacco consumption and harm’). The use of illicit drugs can affect a person’s education, employment and health (including increased illness, disease, accidents and injury). Harmful drug use is associated with family and social disruption, violence and crime (Catto and Thomson 2008, Intergovernmental Committee on Drugs 2014). Property crime, violence, family friction, physical and mental health problems and young people committing suicide are often associated with volatile substance use (Marel, MacLean and Midford 2016). Use of illicit drugs during pregnancy, and associated impacts, is discussed in section 6.2.

In this section, the use of the term ‘illicit substance use’ refers to use of substances which are illegal to possess (such as heroin) and misuse of substances which are legally available (for example, petrol, glue, paint and prescription drugs). Misuse of legal substances (volatile substance use) can result in sudden death, asphyxiation or neurological and cognitive effects.

### Substance use

Nationally in 2014‑15, for Aboriginal and Torres Strait Islander Australians aged 15 years and over 30.6 per cent reported[[4]](#footnote-4) using substances in the 12 months prior to interview (table 11A.2.4). Reported substance use was lower in remote areas (20.9 per cent) than in non‑remote areas (33.2 per cent), and higher for males (34.2 per cent) than females (27.3 per cent) (tables 11A.2.5‑6). Substance use varied across states and territories (table 11A.2.7).

The rest of this section reports data for Aboriginal and Torres Strait Islander Australians aged 18 years and over (aligned with the NIRA age scope of reporting on rates of current daily smokers and levels of risky alcohol consumption).

In 2014‑15, for Aboriginal and Torres Strait Islander adults (in the 12 months prior to interview):

* around two‑thirds (68.6 per cent) reported not having used substances
* the proportion reporting illicit substance use increased from 23.1 per cent in 2002 to 30.8 per cent 2014‑15
* ‘marijuana, hashish or cannabis resin’ was the most commonly used illicit drug (19.6 per cent), followed by ‘analgesics and sedatives’ (13.0 per cent) (table 11A.2.1). This is consistent with the findings from the National Drug Strategy Household Survey, for both the Aboriginal and Torres Strait Islander population and non‑Indigenous population — cannabis was the most commonly used illicit drug, followed by illicit use of pharmaceuticals (AIHW 2014).

| Figure 11.2.1 Substance use for Aboriginal and Torres Strait Islander adults, by sex**a** |
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| Figure 11.2.1 Substance use for Aboriginal and Torres Strait Islander adults, by sex  More details can be found within the text surrounding this image.  |
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| a Relative standard errors and 95 per cent confidence intervals should be considered when interpreting these data, and are available in attachment table 11A.2.2. |
| *Sources*: ABS (unpublished) National Aboriginal and Torres Strait Islander Social Survey 2002, 2008, 2014‑15; ABS (unpublished) National Aboriginal and Torres Strait Islander Health Survey 2004‑05; ABS (unpublished) Australian Aboriginal and Torres Strait Islander Health Survey 2012‑13 (NATSIHS component); table 11A.2.2. |
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In 2014‑15, the proportion of Aboriginal and Torres Strait Islander adults reporting illicit substance use in the previous 12 months (30.8 per cent) was higher than in all earlier survey periods (around 23 per cent in 2002, 2008 and 2012‑13) (table 11A.2.1). The increase in use was largely driven by higher reported non-medical use of ‘analgesics and sedatives’, by both males (11.3 per cent) and females (14.5 per cent), at 2–3 times the rate of earlier survey periods. The increase was also driven by a doubling of the reported use of ‘amphetamines and speed’ by males (from 3.1 per cent in 2012‑13 to 7.0 per cent in 2014‑15) (figure 11.2.1). Between 2012‑13 and 2014‑15, the reported non-medical use of ‘analgesics and sedatives’ tripled across all non‑remote areas (from 5.0 per cent to 17.8 per cent in major cities; 4.5 per cent to 16.4 per cent in inner regional areas and 3.7 per cent to 11.9 per cent in outer regional areas) (table 11A.2.3).

### Drug related hospitalisations

Data on hospitalisations related to drug use are from the AIHW National Hospital Morbidity Database. These data only cover illnesses and conditions directly attributable to drug use that result in admission to a hospital. They do not include conditions where drug use may be a contributing factor but where the link is not direct and immediate.

For this report, hospitalisations data are presented for the non‑Indigenous population from 2012‑13 onwards (for prior years the data are presented for ‘other’ which includes non‑Indigenous Australians and those for whom Indigenous status is unknown or not stated). Prior to 2010‑11, six jurisdictions (NSW, Victoria, Queensland, WA, SA and the NT) were considered to have acceptable quality of Aboriginal and Torres Strait Islander identification in hospitalisation data. The attachment tables for this report include hospitalisations data for all jurisdictions for 2012‑13 to 2014‑15 for Aboriginal and Torres Strait Islander and non‑Indigenous Australians, as well as data for the six jurisdictions for 2004‑05 to 2014‑15 for Aboriginal and Torres Strait Islander and other Australians.

Nationally in 2014‑15, the drug‑related hospitalisation rate for Aboriginal and Torres Strait Islander Australians:

* was 655.3 per 100 000 population, with similar rates for males and females (table 11A.2.8)
* was highest for mental and behavioural disorders (338.7 per 100 000 population) and poisoning (273.0 per 100 000 population) (table 11A.2.8)
* decreased as remoteness increased, rates in major cities were more than twice those of remote areas (845.3 compared with 384.5 per 100 000 population) (table 11A.2.11).

In 2014‑15, after adjusting for differences in population age structures, the hospitalisation rates for Aboriginal and Torres Strait Islander Australians for mental and behavioural disorders and accidental poisoning related to drug use was around three times the rates for non‑Indigenous Australians (table 11A.2.9).

Between 2004‑05 and 2014‑15, after adjusting for differences in population age structures, for NSW, Victoria, Queensland, WA, SA and the NT combined:

* rates of hospitalisation for drug-related poisoning for Aboriginal and Torres Strait Islander Australians increased from 1.4 to 2.3 times the rate for other Australians
* rates of hospitalisation for drug‑related mental and behavioural disorders for Aboriginal and Torres Strait Islander Australians increased from 2.7 to 3.1 times the rate for other Australians (table 11A.2.10).

Hospitalisations related to drug use data by State and Territory are available in table 11A.2.13.

### Drug induced deaths

Mortality data disaggregated by Indigenous status are available for NSW, Queensland, WA, SA and the NT, as these jurisdictions have sufficient levels of Aboriginal and Torres Strait Islander identification and numbers of deaths to support analysis.

For the period 2010–2014, after adjusting for differences in population age structures, for NSW, Queensland, WA, SA and the NT combined, the drug‑induced death rate for Aboriginal and Torres Strait Islander Australians was 1.9 times the rate for non‑Indigenous Australians, with the ratio slightly higher for females (2.2:1) compared to males (1.7:1) (table 11A.2.14). Data are available by State and Territory in table 11A.2.14.

### Drug involvement in homicides

In 2013‑14, there were 237 homicide incidents resulting in 247 victims of homicide (section 4.12, tables 4A.12.29 and 4A.12.31). Of the 237 incidents, the Indigenous status of victims and offenders were known in 175 incidents, among these:

* 24 homicide incidents involved Aboriginal and Torres Strait Islander Australians as both victims and offenders. In five of these incidents, the offender was under the influence of drugs
* 141 homicide incidents involved non‑Indigenous Australians as both victims and offenders. Of these incidents, 44 involved the offender under the influence of drugs (of which 18 also involved the victim under the influence of drugs)
* 10 homicide incidents involved a combination of an Aboriginal and Torres Strait Islander Australian and a non‑Indigenous Australian as either the victim or the offender. Of these homicides, five involved the offender under the influence of drugs (of which one also involved the victim under the influence of drugs) (table 11A.2.15).

The number of Aboriginal and Torres Strait Islander homicide incidents and the influence of drugs on the victim and/or offender are small and are difficult to interpret. Numbers fluctuated with no clear trend over the period 1999‑2000 to 2013‑14 (table 11A.2.15).

### Things that work

Petrol sniffing remains the most prevalent form of volatile substance use among Aboriginal and Torres Strait Islander Australians in remote communities (Marel, MacLean and Midford 2016). Box 11.2.3 provides an example of how petrol sniffing is being addressed.

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| Box 11.2.3 Things that work — drug and other substance use and harm |
| **Low aromatic fuel** was introduced in the NT and WA in 2006 and has since been introduced in Queensland and SA, to reduce the harmful, risky health behaviour of petrol sniffing, and to prevent associated antisocial behaviour, offending and contact with the criminal justice system. Low aromatic fuel has extremely low levels of aromatics making it less attractive for people to sniff in order to get a ‘high’. The most recent evaluation in 2011–2014 undertaken by the Menzies School of Health and Research found: * the introduction of low aromatic fuel is linked with a continuing decline in the numbers and frequency of young people sniffing in remote communities
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| (continued next page) |
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| Box 11.2.3 (continued) |
| * a reduction of 88 per cent in petrol sniffing across the 17 communities surveyed since 2005–07
* in 17 of the 53 communities surveyed where comparative data were available over time, the total number of people sniffing petrol declined from 647 in 2005–07 to 78 in 2013‑14 (d’Abbs and Shaw 2016).

The earlier evaluation emphasised the role of access to services supporting young people to engage in alternative activities that promoted wellbeing (d’ Abbs and Shaw 2008 cited in Osborne, Baum and Brown 2013).  |
| *Sources*: d’Abbs, P. and Shaw, G. 2016, *Monitoring Trends in the Prevalence of Petrol Sniffing in Selected Australian Aboriginal communities 2011–2014: Final Report*, Menzies School of Health Research, NT; d’Abbs, P. and Shaw, G. 2008, *Executive Summary of the Evaluation of the Impact of Opal Fuel*, Commonwealth Department of Health and Ageing; Osborne, K., Baum, F. and Brown, L. 2013, *What works? A review of actions addressing the social and economic determinants of Indigenous health*, Closing the Gap Clearinghouse publication, Issues Paper no. 7 produced for the Closing the Gap Clearinghouse, Australian Institute of Health and Welfare and the Australian Institute of Family Studies, Canberra. |
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### Future directions in data

Data on the use of illicit drugs are derived from surveys which are limited by sampling, survey administration and questionnaire design, and may underestimate actual consumption (Gray and Wilkes 2010; Lee et al. 2014). The sensitive, personal (and sometimes illegal) nature of the behaviours being enquired about may affect respondents’ willingness to respond and the nature of the responses. Results of previous ABS surveys and administrative data collections on use of alcohol and illegal drugs suggest a tendency for respondents to underreport actual consumption levels (ABS 2016), and whilst national surveys may provide a broad indication of the prevalence of drug use any significant regional variation is concealed. Reliable population estimates of substance use and dependence are fundamental to inform funding and the design of initiatives to prevent and treat harmful drug use (Lee et al. 2014).

### References

ABS 2016, *National Aboriginal and Torres Strait Islander Social Survey, 2014-15*, Cat. No. 4714.0, Australian Bureau of Statistics, Canberra.

AIHW (Australian Institute of Health and Welfare) 2014, *National Drug Strategy Household Survey Detailed Report 2013*, Cat. no. PHE 145, Drug statistics series no. 28. Cat. no. PHE 183, AIHW, Canberra, http://www.aihw.gov.au/alcohol-and-other -drugs/ndshs-2013/ (accessed 22 March 2016).

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Gray, D. and Wilkes, E. 2010, *Reducing Alcohol and Other Drug Related Harm*, Resource sheet no. 3 produced for the Closing the Gap Clearinghouse, Australian Institute of Health and Welfare and the Australian Institute of Family Studies.

Intergovernmental Committee on Drugs 2014, *National Aboriginal and Torres Strait Islander Peoples’ Drug Strategy 2014–2019*, A sub-strategy of the National Drug Strategy 2010–2015.

Lee, K., Chikritz, T., Wilson, S., Wilkes, E., Gray, D., Room, R. and Conigrave, K. 2014, ‘Better methods to collect self-reported alcohol and other drug use data from Aboriginal and Torres Strait Islander Australians’, *Drug and Alcohol Review*, vol. 33, no. 5, pp. 466–472.

Marel, C., MacLean, S. and Midford, R. 2016, ‘Review of volatile substance use among Aboriginal and Torres Strait Islander people’, *Australian Indigenous Health Reviews*, no. 16.

## 11.3 Juvenile diversions[[5]](#footnote-5)

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| Box 11.3.1 Key messages |
| * Diversion of young offenders from the criminal justice system can be a swift and economically efficient response to offending, aimed at reducing reoffending and the negative labelling and stigmatisation of contact with the criminal justice system.
* Rates of diversion from formal criminal justice processes for Aboriginal and Torres Strait Islander young people aged 10–17 years are between two‑fifths to two‑thirds (0.4 to 0.7 times) the rates for non‑Indigenous young people (table 11A.3.2).
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| Box 11.3.2 Measures of Juvenile diversions |
| There is one main measure for this indicator. *Juvenile diversions* is defined as the proportion of all alleged young offenders who are diverted from court proceedings (that is, from the formal criminal justice system).The most recent available data are for 2014‑15 (or the 2015 calendar year for some jurisdictions) (NSW, Victoria, Queensland, WA, SA, the NT and the ACT; sex). Data disaggregated by Indigenous status are not available for Tasmania. |
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Aboriginal and Torres Strait Islander Australians are overrepresented in the criminal justice system, as both victims and offenders. Section 4.11 includes information on child protection and section 4.12 includes information on family and community violence. Section 4.13 includes information on imprisonment and juvenile detention.

Diversion from the youth justice system is a critical factor for addressing the overrepresentation of Aboriginal and Torres Strait Islander young people in the criminal justice system (Stewart et al. 2014). Police cautioning and conferencing processes are swift and economically efficient responses to offending. They are aimed at reducing reoffending and the negative labelling and stigmatisation associated with formal contact with the criminal justice system (see section 11.4 on repeat offending) (Allard et al. 2010; Juodo 2008).

Diversion can occur at any point following initial contact with police — pre‑arrest, pre‑trial, pre‑sentence, post‑sentence and pre‑release. While diversion involves any process that prevents young people from entering or continuing in the formal criminal justice system, it typically involves pre‑court processes such as police cautioning or conferencing (Allard et al. 2010; Juodo 2008; Richards 2010).

Cautioning and conferencing are typically available to first time and non‑serious offenders. Sufficient evidence to establish that an offence took place, an admission of guilt and the young person’s consent to engage in the cautioning or conferencing process is required for a diversion to occur (Allard et al. 2010).

Two research studies (on young people who had contact with the youth justice system in NSW, WA, SA; and Queensland) found that, even after controlling for the effects of age, sex, offence type and offending history, Aboriginal and Torres Strait Islander young offenders were less likely than non‑Indigenous young offenders to be diverted (Snowball (2008) and Allard et al (2010) cited in Richards (2010)). However, a number of other factors which could not be assessed may explain at least some of this difference, such as whether the young person was willing to plead guilty (a requirement for eligibility for diversion).

State and Territory governments have individual responsibility for youth diversions (table 11A.3.1 outlines the relevant legislation for each jurisdiction). In each jurisdiction except Queensland, a youth is defined as a person aged 10 to 17 years (in Queensland, a youth is defined as a person aged 10 to 16 years). Children under 10 years of age cannot be held legally responsible for their actions (Richards 2011). Differences in programs and data collection mean that data are not comparable across jurisdictions.

For the most recent year of reporting, rates of diversions for Aboriginal and Torres Strait Islander young people are between two‑fifths to two‑thirds (0.4 to 0.7 times) the rates for non‑Indigenous young people. Within most jurisdictions, proportions of juvenile offenders being diverted have fluctuated over time (table 11A.3.2).

### New South Wales

New South Wales data are from police records and represent persons of interest — alleged offenders who have come to the attention of NSW Police for a recorded criminal incident. Data in previous reports were reported on a different counting methodology and should not be compared with data in this report.

In 2015 (excluding infringement notices), 27.9 per cent of Aboriginal and Torres Strait Islander alleged young offenders received a diversion by police, this is half the rate of non‑Indigenous alleged young offenders receiving a diversion (60.6 per cent) (table 11A.3.2). Rates were relatively steady between 2004 and 2015 (table 11A.3.3).

For Aboriginal and Torres Strait Islander alleged young offenders who were diverted, the most common type of offence was ‘theft’ (28.7 per cent). For non‑Indigenous alleged offenders, the greatest proportion of diversions were for the offence of ‘transport regulatory offences’ (52.4 per cent) followed by theft (12.3 per cent) (table 11A.3.6).

### Victoria

Indigenous status data are based on responses to the ABS Standard Indigenous Question when asked by Victoria Police. Victorian data in previous reports were reported on a different basis and should not be compared with data in this report.

In 2014‑15, 14.0 per cent of Aboriginal and Torres Strait Islander alleged young offenders were formally cautioned, around two‑fifths the rate of non‑Indigenous alleged young offenders (35.1 per cent) (table 11A.3.2). The diversion rate for Aboriginal and Torres Strait Islander alleged young offenders has fluctuated between 14.0 per cent and 25.2 per cent in the time period between 2004‑05 and 2014‑15 (table 11A.3.7). The diversion rate for non‑Indigenous alleged young offenders has declined from a high of 47.1 per cent in 2006‑07 to 35.1 per cent in 2014‑15 (table 11A.3.7).

In 2014‑15, the most common type of offence for both Aboriginal and Torres Strait Islander alleged young offenders and non‑Indigenous alleged young offenders was ‘property and deception offences’ (around 60 per cent) followed by ‘offences against the person’ (around 25 per cent) (table 11A.3.9). Data by sex and offence type are available in table 11A.3.8 and historical data by type of offence in tables 11A.3.10­–19.

### Queensland

In 2014‑15, 24.1 per cent of Aboriginal and Torres Strait Islander alleged young offenders were cautioned or had a community conference (table 11A.3.2). The diversion rate for Aboriginal and Torres Strait Islander alleged young offenders has fluctuated between 24.0 per cent and 32.0 per cent in the period between 2006‑07 and 2014‑15 (table 11A.3.20). The diversion rate for non‑Indigenous alleged young offenders has decreased from 57.6 per cent in 2006‑07 to 44.5 per cent in 2014‑15 (table 11A.3.20).

In 2014‑15, for all alleged young offenders, the most common types of offence continues to be offences against property including ‘unlawful entry’ and ‘theft’ (66.5 per cent for Aboriginal and Torres Strait Islander, and 50.5 per cent for non‑Indigenous, alleged young offenders) (table 11A.3.21–29).

### Western Australia

In 2014‑15, 38.0 per cent of Aboriginal and Torres Strait Islander alleged young offenders were diverted through caution or transferred to a Juvenile Justice Team, compared with 54.7 per cent of non‑Indigenous alleged young offenders (table 11A.3.2). The diversion rate for Aboriginal and Torres Strait Islander alleged young offenders has fluctuated between 29.5 per cent and 40.5 per cent in the seven years of reporting from 2008‑09. The diversion rate for non‑Indigenous alleged young offenders has steadily decreased from 59.9 per cent in 2008‑09 to 54.7 per cent in 2014‑15 (table 11A.3.30). Data by sex and offence type are available in table 11A.3.31.

### South Australia

In 2015, 28.8 per cent of Aboriginal and Torres Strait Islander alleged young offenders were diverted through formal caution or transfer to family conference, compared with 46.7 per cent for non‑Indigenous alleged young offenders (table 11A.3.2). The difference between Aboriginal and Torres Strait Islander and non‑Indigenous youth diversions has remained similar since 2008 at around 20 percentage points (table 11A.3.32).

In 2015, the most common types of offences for both Aboriginal and Torres Strait Islander and non‑Indigenous alleged young offenders was ‘breach of custodial/community orders’, ‘theft’, ‘property damage and environmental pollution’ and ‘unlawful entry with intent/burglary’, accounting for half of all offences (table 11A.3.34). Data by sex and offence type are available in table 11A.3.33 and historical data by type of major offence in tables 11A.3.35­–41.

### Australian Capital Territory

In the ACT, the proportion of youth diversions has been calculated on total recorded police contacts with young people, which includes youth cautions, referrals to diversionary conferencing, young people taken into protective custody and charges pertaining to young people.

In 2014‑15, 16.1 per cent of Aboriginal and Torres Strait Islander alleged young offenders were diverted, compared with 42.8 per cent of non‑Indigenous alleged young offenders (table 11A.3.2). Data on diversions by sex are available in table 11A.3.42.

### Northern Territory

Northern Territory police data refer to apprehension cases rather than individual persons, and several cases can relate to the same offender. The Youth Justice Act places a limit of two referrals to diversion. If a youth is not complying with the provisions of the diversion, the matter is referred for prosecution through court (NTFES 2015).

In 2015, 32.6 per cent of Aboriginal and Torres Strait Islander alleged young offenders were diverted, compared with 47.9 per cent of non‑Indigenous alleged young offenders (table 11A.3.2). The diversion rate for Aboriginal and Torres Strait Islander alleged young offenders has fluctuated between 24.9 per cent and 43.2 per cent in the period between 2002 to 2015 (table 11A.3.43).

Of the 1766 Aboriginal and Torres Strait Islander alleged youth offenders, 1098 (62.2 per cent) were denied diversion as a result of the seriousness of the offence or reoffending and 92 (5.2 per cent) declined to participate in diversion (table 11A.3.44).

In 2015, the most common offence type for Aboriginal and Torres Strait Islander alleged young offenders was ‘crime against property’ accounting for around three‑quarters of all offences (table 11A.3.45).

### Things that work

A program that has engaged Aboriginal and Torres Strait Islander alleged young offenders is described in box 11.3.3.

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| Box 11.3.3 Things that work — juvenile diversions |
| The **Tiwi Islands Youth Development and Diversion Unit** (TIYDDU) (NT) based in Wurrumiyanga has been operating since 2003. The program provides a 12‑week diversion program engaging Tiwi youth (typically first‑time youth offenders) in prevention activities that aim to benefit the offender, the victim and the community. The care and support provided to the young people recognises, integrates, and shows respect for Tiwi value and social and cultural authority. Community members were involved in its design and play an important role in its ongoing implementation (Stewart et al 2014; CTGCH 2014).An independent evaluation of the TIYDDU, conducted in 2011 by the Australian Institute of Criminology (Stewart et al 2014), found it was effective in reducing adverse contact between Tiwi youth and the criminal justice system. Individual re‑offence data from NT Police for program participants showed that 20 per cent of participants (13 of 65 young people) had contact with the police for alleged offences in the year following commencement with the program — below what would be expected for this population without the intervention. Data are not available for comparisons with youth that did not participate in the program during this time, and further assessment of the outcomes from this program by comparing with a similar group who did not participate would be desirable.Qualitative data (based on interviews with program staff, participants, community members and representatives of agencies with which TIYDDU collaborates) found the program was useful in reconnecting young people to cultural norms, was culturally ‘competent’ and directly addressed the factors that contribute to offending behaviour, such as substance misuse, boredom and disengagement from work or education. School attendance data for individuals were requested but unable to be provided due to confidentiality and small numbers. |
| *Sources*: CTGCH (2014) *Law and Justice: Prevention and Early Intervention Programs for Indigenous Youth*, Resource sheet no. 34 produced by the Closing the Gap Clearinghouse, Australian Institute of Health and Welfare and Australian Institute of Family Studies; Stewart et al (2014), *Indigenous Youth Justice Programs Evaluation*, Australian Institute of Criminology.  |
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### Future directions in data

Comparable and complete national data are yet to become available to illustrate the nature or level of diversion undertaken by Australian jurisdictions. Whilst data are collected on alleged offenders in the ABS Recorded Crime Offenders collection, the data quality for diversions by Indigenous status is currently not sufficient for national reporting purposes. The Aboriginal and Torres Strait Islander status of an alleged offender is based on self‑identification by the individual who comes into contact with police. Aboriginal and Torres Strait Islander identification is difficult to ascertain where police proceed by way of a penalty/infringement notice, as this method does not usually provide an opportunity for police to ask individuals to self‑identify (ABS unpublished).

To assist in explaining the differences in diversion rates between Aboriginal and Torres Strait Islander and non‑Indigenous youth, information is also required on whether alleged offenders were denied diversion due to not meeting eligibility criteria, availability of diversion programs or declining to participate in diversion.

### References

Allard, T., Stewart, A., Chrzanowski, A., Ogilvie, J., Birks, D. and Little, S. 2010, *Police Diversion of Young Offenders and Indigenous Over-Representation*, Trends & Issues in Crime and Criminal Justice, No. 390, Australian Institute of Criminology.

Juodo, J. 2008, *Responding to Substance Abuse and Offending in Indigenous Communities: Review of Diversion Programs*, Research and Public Policy Series, No. 88, Australian Institute of Criminology.

NTFES 2015, *Northern Territory Police, Fire and Emergency Services, 2014-15 Annual Report*.

Richards, K. 2010, *Police-Referred Restorative Justice for Juveniles in Australia*, Trends & Issues in Crime and Criminal Justice, No. 398, Australian Institute of Criminology.

Richards, K. 2011, *What Makes Juvenile Offenders Different from Adult Offenders?*, Trends & Issues in Crime and Criminal Justice, No. 409, Australian Institute of Criminology.

Stewart, J., Hedwards, B., Richards, K., Willis, M. and Higgins, D. 2014, *Indigenous Youth Justice Programs Evaluation*, Australian Institute of Criminology.

## 11.4 Repeat offending[[6]](#footnote-6)

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| Box 11.4.1 Key messages |
| * Repeat offending and re‑incarceration are significant contributors to the overrepresentation of Aboriginal and Torres Strait Islander Australians in the youth justice and criminal justice systems.
* Nationally on 30 June 2015, 77.2 per cent of Aboriginal and Torres Strait Islander prisoners and 50.4 per cent of non‑Indigenous prisoners had a known prior imprisonment. These proportions have remained relatively unchanged over the last 15 years (figure 11.4.1).
* A higher proportion of Aboriginal and Torres Strait Islander male prisoners (78.1 per cent) than Aboriginal and Torres Strait Islander female prisoners (68.9 per cent) had experienced prior adult imprisonment (table 11A.4.2).
* In 2014-15, 52.8 per cent of Aboriginal and Torres Strait Islander young people returned to youth justice supervision, similar to 2013-14 and 1.6 times the rate of non‑Indigenous young people (table 11A.4.5).
* In NSW, Queensland, SA, ACT and the NT in 2014‑15, 30 to 49 per cent of Aboriginal and Torres Strait Islander offenders were proceeded against by police on more than one occasion, compared with 15 to 31 per cent of non‑Indigenous offenders (table 11A.4.7).
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| Box 11.4.2 Measures of repeat offending |
| There is currently no systematic national definition and data collection of repeat offending. This section focuses on the re‑incarceration aspect of repeat offending. There are two main measures for this indicator. * *Adult re‑imprisonment* is defined as the proportion of prisoners currently under sentence with known prior adult imprisonment
* *Youth returns to sentenced supervision* is defined as the proportion of young people who return to sentenced supervision.

The most recent available data for adult re‑imprisonment are from the ABS Prisoners in Australia collection for 30 June 2015 (all jurisdictions; sex). The most recent available data for returns to sentenced supervision are from the AIHW Juvenile Justice National Minimum Dataset 2014-15 (national). A supplementary measure on the proportion of offenders who were proceeded against by police on more than one occasion is also reported (NSW, Queensland, SA, ACT and the NT; age; sex). |
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This section focuses on repeat offending. Imprisonment and juvenile detention are covered under section 4.13. Juvenile diversions are covered under section 11.3.

Repeat offending or recidivism refers to repetitious criminal activity. Repeat offending and re‑incarceration are significant contributors to the overrepresentation of Aboriginal and Torres Strait Islander Australians in the youth justice and criminal justice systems (CTGCH 2013; Snowball and Weatherburn 2006). A reduction in the number of repeat offenders can have a significant effect on the overall volume of juvenile contacts with the criminal justice system (Lind 2011). Modest reductions in the rate at which offenders are re‑imprisoned would result in substantial savings in prisoner numbers and correctional outlays (Weatherburn et al. 2009).

Many factors contribute to the re‑offending behaviour of an individual. Demographic characteristics such as age, sex and Indigenous status are significant predictors of re‑offending (Lind 2011; Ringland, Weatherburn and Poynton 2015). Situational factors such as substance abuse, family problems, peer delinquency and school related problems (levels of school attendance/truancy, or suspension or expulsion) have also been found to be significant predictors of re‑offending (Ringland, Weatherburn and Poynton 2015), which are generally more prevalent for Aboriginal and Torres Strait Islander than non‑Indigenous Australians (see for example, sections 4.5, 4.11, 11.1 and 11.2).

Common reasons for Aboriginal and Torres Strait Islander prisoners’ return to custody whilst on parole include breaching parole conditions, committing further offences, lack of employment, lack of housing, substance abuse and domestic violence (Apted, Hew and Sinha 2013).

The true level of repeat offending is underestimated, as not all offences are necessarily detected or recorded by police, and court convictions do not necessarily result in contact with corrective services (Payne 2007; Richards 2011). Repeat offending can also be overestimated as an offender on remand will not necessarily be convicted and sentenced for a particular offence (Payne 2007).

### Adult re‑imprisonment

In the absence of actual re‑offending data, studies use criminal justice data and define repeat offending as re‑apprehension, re‑conviction or re‑imprisonment. Re‑imprisonment is the most serious outcome of the criminal justice process and research has found that the strongest predictor of a return to prison was the number of prior imprisonment terms (Wundersitz 2010).

Nationally on 30 June 2015, 77.2 per cent of Aboriginal and Torres Strait Islander prisoners and 50.4 per cent of non‑Indigenous prisoners had a known prior imprisonment. These proportions have remained relatively unchanged over the past 15 years (figure 11.4.1).

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| Figure 11.4.1 Proportion of prisoners with known prior adult imprisonment under sentence, at 30 June**a** |
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| Figure 11.4.1 Proportion of prisoners with known prior adult imprisonment under sentence, at 30 June  More details can be found within the text surrounding this image.  |

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| a In 2005, data were not available for the ACT and for a National total. |
| *Source*: ABS (2015) *Prisoners in Australia, 2015*, Cat. no. 4517.0; table 11A.4.1. |
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Nationally, the proportion of Aboriginal and Torres Strait Islander male (78.1 per cent) and female (68.9 per cent) prisoners with known prior adult imprisonment was 1.5 and 1.8 times that of non‑Indigenous male (51.3 per cent) and female (39.3 per cent) prisoners (table 11A.4.2).

### Youth returns to sentenced supervision

Most young people who have a supervised sentence[[7]](#footnote-7) have only one, and never return to sentenced youth justice supervision. However, 26.8 per cent of Aboriginal and Torres Strait Islander young people who had initially been sentenced to community-based supervision and 41.8 per cent of those initially sentenced to detention had received a total of 5 or more supervised sentences before they turned 18 years of age (AIHW 2015, AIHW 2016). Data are presented for returns over three time frames:

* in 2014-15, during the entire time for which a young person is eligible to return to *youth justice supervision*, 52.8 per cent of Aboriginal and Torres Strait Islander young people returned to sentenced supervision, similar to 2013-14 and 1.6 times the rate of non‑Indigenous young people (table 11A.4.5)
* within 12 months of release from *detention* — in 2014­‑15, Aboriginal and Torres Strait Islander young males returned to detention (78.7 per cent) at a similar rate as non‑Indigenous young males (76.7 per cent). A greater proportion of Aboriginal and Torres Strait Islander young females returned to detention (56.3 per cent) than non‑Indigenous females (42.1 per cent) similar to patterns in 2013-14 (table 11A.4.6)
* data are available on returns within 6 months, but are subject to fluctuation. In 2014-15, Aboriginal and Torres Strait Islander young people returned to community-based supervision at 1.5 times the rate of non-Indigenous young people (table 11A.4.6).

### Offenders proceeded against more than once by police

People first enter the justice system when they are investigated by police for allegedly committing an offence. They may be proceeded against by police — have a legal action against them — via court actions or non‑court actions. An offender can be proceeded against by police multiple times during a given period.

Comparable data are available for NSW, Queensland, SA, ACT and the NT. In 2014‑15, for these five jurisdictions, 30 to 49 per cent of Aboriginal and Torres Strait Islander offenders were proceeded against by police on more than one occasion, compared with 15 to 31 per cent of non‑Indigenous offenders (table 11A.4.7). Aboriginal and Torres Strait Islander offenders proceeded against by police were younger than non‑Indigenous offenders for both males and females in NSW, Queensland, SA and for males in the ACT and NT (table 11A.4.8).

### Things that work

The Standing Committee on Social Issues (2008) found that a major factor leading to recidivism was the lack of suitable support available to ex‑offenders attempting to integrate themselves into society. Services that aim to support Aboriginal and Torres Strait Islander offenders who have experienced imprisonment can enhance rehabilitative outcomes and the reintegration process, by helping offenders remain in contact, and involved, with the community. These services can include; visits by elders, contact with community liaison officers, official Aboriginal and Torres Strait Islander visitors and access to chaplains (including specified Aboriginal and Torres Strait Islander chaplains) (Willis and Moore 2008).

Diversion programs aim to reduce reoffending and reduce dependency on drugs and alcohol in view of their large contribution to offending (and reoffending) (CTGCH 2013). Box 11.4.3 describes an example of a diversion program that has shown reductions in recidivism.

| Box 11.4.3 Things that work — repeat offending |
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| In NSW, the **Magistrates Early Referral into Treatment** (MERIT) drug diversion program provides adult defendants in local courts with the option of undertaking formal drug treatment while on bail. The program is available in 65 local courts across NSW covering around 80 per cent of defendants. Participation in the program is voluntary. In 2009, approximately 19 per cent of MERIT participants were Aboriginal and/or Torres Strait Islander (Howard and Martire 2012).MERIT is a tailored, case management program that diverts defendants with demonstrable drug problems to an intensive three‑month drug treatment program, and occurs prior to sentencing. Lulham (2009) compared a cohort of 2396 defendants who participated in the MERIT program in the two years to 30 June 2005 (18 per cent Aboriginal and Torres Strait Islander) with a comparison group of defendants (15 per cent Aboriginal and Torres Strait Islander) and found that completion of the program reduced reoffending by 12 per cent over a two‑year follow‑up period. No comparable decline was noted among those who failed to complete the program. Whilst an audit by the NSW Auditor‑General in 2007‑08 agreed that the MERIT program was suitable for Aboriginal and Torres Strait Islander defendants, it found that they faced issues with access to, and completion of, the MERIT program. An Aboriginal Practice Checklist to improve access was developed and trialled by seven MERIT teams in 2006. Whilst completion rates for Aboriginal and Torres Strait Islander defendants in these areas increased from 55 to 73 per cent, the Checklist has not been implemented by all MERIT teams (Public Accounts Committee 2010). |
| *Sources*: Howard, M. and Martire, K. 2012, ‘*Magistrates Early Referral into Treatment: An overview of the MERIT program as at June 2011’*, Crime Prevention Issues, http://www.merit.lawlink.nsw.gov.au/agdbasev7wr/\_assets/merit/m771020l1/issue\_9\_bulletin\_may\_2012.pdf (accessed 27 May 2014); Lulham, R. 2009, ‘*The Magistrates Early Referral Into Treatment Program: Impact of program participation on re‑offending by defendants with a drug use problem’*, Crime and Justice Bulletin, vol. Contemporary Issues in Crime and Justices no. 131; Public Accounts Committee 2010, ‘*Helping Aboriginal defendants through MERIT*’ in Seventh Report on the Examination of the Auditor‑General’s Performance Audits, New South Wales. MERIT program also cited in (CTGCH 2013), *Diverting Indigenous offenders from the criminal justice system*, Resource sheet no. 24 produced for the Closing the Gap Clearinghouse; NIDAC (2012), *An economic analysis for Aboriginal and Torres Strait Islander offenders Prison vs residential treatment*, Australian National Council on Drugs research paper 24, Canberra. |
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### Future directions in data

There is no systematic national definition or data collection which provides information about the prevalence of prior detention among juvenile detainees. The Australasian Juvenile Justice Administrators is overseeing several research projects to develop national youth justice policy, research and data capabilities. The Australian Bureau of Statistics is working with corrective services agencies to explore ways to improve prisoner flow data to build a more accurate picture of incarceration. There also needs to be more rigorous evidence of effectiveness and evaluation of efforts to reduce imprisonment.

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## 11.5 Community functioning[[8]](#footnote-8)

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| Box 11.5.1 Key messages |
| * Community functioning is defined as the ability and freedom of community members and communities to determine the context of their lives and to translate their capabilities into positive actions towards a valued life.
* Themes important to community functioning are: connectedness to country, land and history, culture and identity; resilience; leadership; having a role, structure and routine; feeling safe; and vitality. Whilst there is no overall measure of community functioning, considering outcomes across the six themes builds an overall picture.
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| Box 11.5.2 Measures of community functioning |
| There is no main measure for this indicator. Community functioning is a complex concept and includes analysis of a range of factors. Descriptors and findings are reported for:* the six themes of community functioning
* selected variables contributing to each community functioning theme.

Themes and findings are drawn from the work undertaken for the Australian Health Ministers’ Advisory Council Aboriginal and Torres Strait Islander Health Performance Framework (ATSIHPF). The most recent available data are from the ABS National Aboriginal and Torres Strait Islander Social Survey (NATSISS) for 2014‑15 (national; remoteness). |
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Community functioning is defined as the ability and freedom of community members and communities to determine the context of their lives (physical, social, cultural, spiritual and organisational) and to translate their knowledge, skills, and understanding (capabilities) into positive actions towards a valued life (AIHW 2015; OATSIH 2004). The conversion of capabilities into functioning is influenced by the values and personal characteristics of individuals, families and communities, and the environment in which they live. Different cultures will give greater or lesser priority to different aspects of functioning (AHMAC 2012, 2015). Aboriginal and Torres Strait Islander understandings of community and community functioning differ from Western understandings (Taylor et al. 2011). Community functioning for Aboriginal and Torres Strait Islander Australians should be assessed within a framework that reflects their values.

Workshops led by Aboriginal facilitators, on behalf of the work program for the ATSIHPF report[[9]](#footnote-9), developed the concept of community functioning with Aboriginal and Torres Strait Islander Australians in 2008 and 2010. Participants identified a number of key themes and weighted these according to their relative value (table 11.5.1). The multiple constructs in combination build an overall picture of community functioning for Aboriginal and Torres Strait Islander Australians.

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| Table 11.5.1 Themes contributing to community functioning |
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| **Measure of functioning/Weight (per cent)** | **Descriptor** |
| **Connectedness to country, land and history, culture and identity** (25 per cent) | * Being connected to country, land, family and spirit
* Strong and positive social networks with Aboriginal and Torres Strait Islander Australians
* Strong sense of identity and being part of a collective (knowing where you are from, who is your family)
* Sharing; giving and receiving; trust; love; looking out for others
* Engaged/communicative
 |
| **Resilience** (20 per cent) | * Coping with the internal and external world
* Power to control choices and options
* Ability to proceed in public without shame
* Optimising what you have
* Challenge injustice and racism, stand up when required
* Cope well with difference, flexibility and accommodating
* Ability to walk in two worlds
* Engaged in decision making
* External social contacts
 |
| **Leadership** (20 per cent) | * Strong elders in family and community, both male and female
* Role models, both male and female
* Strong direction, vision
* The ‘rock‘, someone who has time to listen and advise
 |
| **Having a role, structure and routine** (15 per cent) | * Having a role for self: participation, contributing through paid and unpaid roles
* Capabilities and skills derived through social structures and experience through non‑formal education
* Knowing boundaries and acceptable behaviours
* Sense of place — knowing your place in family and society
* Being valued and acknowledged
* Disciplined
 |
| **Feeling safe** (10 per cent) | * Lack of physical and lateral violence
* Safe places
* Emotional security
* Cultural competency
* Relationships that can sustain disagreement
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| **Vitality** (10 per cent) | * Community infrastructure
* Access to services
* Education
* Health
* Income
* Employment
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| *Source*: AHMAC (2015) *Aboriginal and Torres Strait Islander Health Performance Framework 2014 Report*, Canberra. |
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### Findings for community functioning themes

A summary of key findings using data from the 2014‑15 NATSISS is outlined for each community functioning theme. Further survey results of selected variables contributing to community functioning themes are available in table 11A.5.1, with 2002 and 2008 data reported where comparable. Data by remoteness areas are in table 11A.5.3 for 2014‑15 and table 11A.5.6 for 2008.

#### Connectedness to country, land and history, culture and identity

Nationally in 2014‑15, for Aboriginal and Torres Strait Islander Australians:

* 74.1 per cent recognised their homelands, similar to 71.7 per cent in 2008 and 70.0 per cent in 2002. A higher proportion of Aboriginal and Torres Strait Islander Australians in remote (83.9 per cent) and very remote (90.8 per cent) areas recognised homelands compared to those in major cities (67.4 per cent)
* 62.3 per cent identified with a clan or language group, similar to 62.1 per cent 2008
* 94.6 per cent had contact with family or friends outside the household at least once per week, similar to 94.0 per cent in 2008
* 82.4 per cent had friends to confide in
* 89.7 per cent feel able to have a say with family and friends, some or more of the time. A higher proportion of Aboriginal and Torres Strait Islander Australians in major cities (91.4 per cent) felt able to have a say compared to those in remote (87.6 per cent) and very remote areas (83.8 per cent) (tables 11A.5.1 and 11A.5.3).

Refer to sections 5.1 ‘Valuing Indigenous Australians and their cultures’, 5.7 ‘Participation in community activities’ and 5.8 ‘Access to traditional lands and waters’ for further information.

#### Resilience

Nationally in 2014‑15, for Aboriginal and Torres Strait Islander Australians:

* 85.9 per cent did not avoid situations due to past unfair treatment
* 89.4 per cent felt they were able to find general support from outside the household
* 59.1 per cent had provided support to someone outside their household in the last four weeks
* 80.8 per cent agreed their doctor could be trusted and 70.4 per cent agreed that the local school could be trusted. A higher proportion of Aboriginal and Torres Strait Islander Australians in major cities (83.3 per cent) felt their doctor could be trusted compared to those in remote (79.9 per cent) and very remote areas (76.2 per cent), with the direction reversed for trust in their local school (72.7 per cent in remote areas and 81.9 per cent in very remote areas, compared to 67.9 per cent in major cities)
* 19.9 per cent had involvement with an Aboriginal or Torres Strait Islander organisation, similar to 18.2 per cent 2008
* 96.9 per cent of adults participated in sport/social/community activities in the last 12 months (tables 11A.5.1 and 11A.5.3).

Refer to sections 5.1 ‘Valuing Indigenous Australians and their cultures’ and 5.7 ‘Participation in community activities’ for further information.

#### Leadership

Nationally in 2014‑15, for Aboriginal and Torres Strait Islander Australians:

* 43.8 per cent of children aged 4–14 years had spent time with an Aboriginal or Torres Strait Islander leader or elder in the last week (table 11A.5.1).

Refer to section 5.4 ‘Case studies in governance’ for further general information on leadership and governance.

#### Having a role, structure and routine

Nationally in 2014‑15, for Aboriginal and Torres Strait Islander Australians:

* 77.1 per cent had lived in only one dwelling in the last 12 months or longer
* 95.5 per cent of children aged 0–14 years had participated in informal learning activities with their main carer in the last week (table 11A.5.1).

#### Feeling safe

Nationally in 2014‑15, for Aboriginal and Torres Strait Islander Australians:

* 77.7 per cent had not experienced physical and/or threatened violence in the last 12 months, similar to 75.3 per cent in 2008
* 84.0 per cent felt safe at home alone after dark
* 54.3 per cent of children aged 2–14 years were taught Indigenous culture at school
* 96.8 per cent had not been incarcerated in the last five years (91.2 per cent had never been incarcerated in their lifetime) (table 11A.5.1).

#### Vitality

* 55.0 per cent had no disability or (restrictive) long‑term health condition
* 66.4 per cent had low/moderate level of psychological distress
* 75.3 per cent could easily get to places needed, similar to 73.8 per cent 2008 (table 11A.5.1).

Refer to sections 5.3 ‘Engagement with services’, 4.3 ‘Early childhood education’, 4.4 ‘Reading, writing and numeracy’, 4.6 ‘Year 12 attainment’, 4.7 ‘Employment’, 4.8 ‘Post‑secondary education’, 4.9 ‘Disability and chronic disease’, 4.10 ‘Household and individual income’, and chapter 8 ‘Healthy lives’ for further information on factors connected to vitality.

### Things that work

Box 11.5.3 provides an example of a cultural healing program that has been found to increase the capacity of participants to exert greater control over their health and wellbeing.

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| Box 11.5.3 Things that work — community functioning |
| The **Family Wellbeing Program** was developed in 1993 by Adelaide‑based Aboriginal and Torres Strait Islander Australians and was originally delivered at a community level, where Aboriginal people could come together over lunch and discuss issues and learn to cope with grief and loss in new ways. Through the action of grassroots community networks, the program has transferred to 56 sites across most states and territories, to more than 3300 participants, 91 per cent of whom were Aboriginal and Torres Strait Islander Australians (Monson‑Wilbraham 2015). The central objective of Family Wellbeing is to develop people’s skills and capacity to move from a position of disempowerment to empowerment. It is a cultural healing program that aims to enhance participants’ awareness, resilience and problem‑solving ability, to improve their sense of wellbeing and to help others (Tsey and Every 2000). The program is now an accredited six‑month Certificate II in Family Wellbeing course delivered by TAFE SA, Batchelor Institute of Indigenous Tertiary Education (NT) and James Cook University (Queensland) (Monson‑Wilbraham 2015). The qualification is an education and counselling skills program focused on dealing with grief, loss and family violence (Tsey and Every 2000).A synthesis of seven formative evaluations of the program, which involved a total of 148 adult and 70 student participants, concluded that it increased the capacity of participants to exert greater control over their health and wellbeing (Tsey et al. 2010 cited in CTGCH 2013). (However, there was no evidence presented of positive changes occurring at the broader, community level.) |
| *Sources*: Monson‑Wilbraham, L. 2015, *Watering the Garden of Family Wellbeing: Empowering Aboriginal and Torres Strait Islander People to Bloom and Grow*, report prepared for the Lowitja Institute, Adelaide; Tsey, K. and Every, A. 2000, *Evaluating Aboriginal Empowerment Programs: the Case of Family WellBeing*, Department of Social Preventative Medicine, University of Queensland and Institute for Aboriginal Development, Alice Springs, Northern Territory, *Australian and New Zealand Journal of Public Health*, 24(5):509–14; Closing the Gap Clearinghouse 2013, *Strategies and Practices for Promoting the Social and Emotional Wellbeing of Aboriginal and Torres Strait Islander People,* Resource sheet no. 19, produced for the Closing the Gap Clearinghouse February 2013, Australian Institute of Health and Welfare and the Australian Institute of Family Studies. |
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### Future directions in data

Data required to inform the findings for community functioning themes are only available every six years. There is no main measure for this indicator and no single national quantitative measure that demonstrates the strengths and capabilities of Aboriginal and Torres Strait Islander Australian families and communities.

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1. The Steering Committee notes its appreciation to Dr Kyllie Cripps, University of NSW, who reviewed a draft of this section of the report. [↑](#footnote-ref-1)
2. The difference between remote (39.4 per cent) and outer regional (33.8 per cent) areas was not statistically significant. [↑](#footnote-ref-2)
3. The Steering Committee notes its appreciation to Dr Kyllie Cripps, University of NSW, who reviewed a draft of this section of the report. [↑](#footnote-ref-3)
4. Substance use questions were self-completed by respondents in non-remote areas, whereas respondents in remote areas were asked these questions via personal interview. [↑](#footnote-ref-4)
5. The Steering Committee notes its appreciation to Dr Kyllie Cripps, University of NSW, who reviewed a draft of this section of the report. [↑](#footnote-ref-5)
6. The Steering Committee notes its appreciation to Dr Kyllie Cripps, University of NSW, who reviewed a draft of this section of the report. [↑](#footnote-ref-6)
7. There are two types of supervised sentences: supervised community-based sentence and sentence of detention. The two combined are referred to as sentenced youth justice supervision. [↑](#footnote-ref-7)
8. The Steering Committee notes its appreciation to Dr Kyllie Cripps, University of NSW, who reviewed a draft of this section of the report. [↑](#footnote-ref-8)
9. This work program was based in the Department of Health until 2013, and is now based in the Department of the Prime Minister and Cabinet. [↑](#footnote-ref-9)