# 11 Safe and supportive communities

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| Strategic areas for action |
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Safe and supportive families and communities provide a resilient, caring and protective environment, promoting a range of positive outcomes. However, the history of colonisation and intergenerational trauma has deeply affected Aboriginal and Torres Strait Islander people as individuals and communities in many ways. This trauma has contributed to family and community disruption, alcohol and drug misuse, violence and harm, and contact with the justice system.

The indicators in this strategic area for action focus on the key factors that affect the safety and supportiveness of 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, 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, and family and social disruption
* youth 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. Strong communities, as defined by Aboriginal and Torres Strait Islander people, 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 youth detention (section 4.13).

Outcomes in this strategic area can be affected by outcomes in other strategic areas, 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/oid2020).

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

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| Box 11.1.1 Key messages |
| * Drinking alcohol at harmful levels comes with social and financial burden to the drinker, their families, and the people and community around them. Alcohol contributes to disability and death, family violence and the burden of disease. * More than one-quarter of Aboriginal and Torres Strait Islander adults abstain from alcohol, with the proportion significantly higher in very remote areas. In 2018‑19, 26 per cent reported not consuming alcohol in the previous 12 months (including those who have never consumed alcohol). The proportion of abstainers in very remote areas (43 per cent) was double that in major cities (19 per cent). * But some Aboriginal and Torres Strait Islander adults put themselves at risk of harm by exceeding alcohol consumption guidelines. In 2018-19, 20 per cent reported exceeding lifetime alcohol risk guidelines (drinking an average of more than two standard drinks per day in the last week) and 53 per cent reported exceeding single occasion risk guidelines (drinking more than four standard drinks on a single occasion) on at least one occasion in the last twelve months. * A higher proportion of Aboriginal and Torres Strait Islander adults abstain from alcohol than  non-Indigenous adults, but in turn a higher proportion of Aboriginal and Torres Strait Islander adults exceed alcohol risk guidelines. * In line with the higher proportion of Aboriginal and Torres Strait Islander adults exceeding alcohol risk guidelines, they are overrepresented in hospitalisations and in deaths from alcohol-related conditions – though with considerably lower numbers, and noting hospitalisations and deaths cover all ages. After adjusting for differences in population age structures, for both alcohol-related hospitalisations and alcohol‑induced deaths, the rate for Aboriginal and Torres Strait Islander people was around four times the rate for non-Indigenous people. * The main component of the higher hospitalisation rates of Aboriginal and Torres Strait Islander people from alcohol-related conditions was hospitalisations in remote areas for acute intoxication — in 2016–2018 this rate was more than four times the rate in 2010–2012, and is now 18 times the rate for non-Indigenous hospitalisations. * Programs and services to manage structural and individual risks for people who drink alcohol at risky levels can include restricting access to alcohol, inhibiting the appeal of alcohol and improving people’s mental wellbeing. * In 2017‑18, the proportion of Aboriginal and Torres Strait Islander homicides involving both the victim and offender having consumed alcohol at the time of the offence (55 per cent — 11 out of 20) was higher than the proportion for non‑Indigenous homicides (16 per cent — 22 out of 135). But for homicides where neither the victim nor offender drank, less than seven per cent were Aboriginal and Torres Strait Islander homicides, indicating overrepresentation for non‑Indigenous people (albeit from very small numbers). |
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| Box 11.1.2 Measures of alcohol consumption and harm |
| There is one main measure for this indicator:   * *Levels of risky alcohol consumption* isdefined as the proportion of people aged 18 years or 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)[[2]](#footnote-2).   The most recent available data are from the ABS National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) for 2018‑19 (all jurisdictions and remoteness). Data are provided for the population aged 18 years or over (for the main measure, which aligns with the National Indigenous Reform Agreement[[3]](#footnote-3)) with supplementary data provided on the population aged 15 years or over.  Three supplementary measures are also reported:   * Alcohol related hospitalisations (all jurisdictions; sex; remoteness)[[4]](#footnote-4) * Alcohol induced deaths (NSW, Queensland, WA, SA and the NT; sex) * Alcohol involvement in homicides (national).   Data on hospitalisations are from the AIHW National Hospital Morbidity Database. Latest data are for 2018-19. Data on deaths are from the ABS Causes of Death collection and latest data are for 2018. Data on homicides are from the Australian Institute of Criminology National Homicide Monitoring Program and latest data are for 2017-18. |
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Australian adults drink alcohol for a range of societal and cultural reasons, and most do not drink at levels that place them at risk of harm. For children and young people under the age of 18 years there is no ‘safe’ or ‘no-risk’ level of drinking alcohol (NHMRC 2019). In Australia, people under the age of 18 years are prohibited from purchasing or consuming alcohol, and people who sell or supply liquor to minors are committing an offence.

Drinking alcohol at harmful levels can create social and financial burdens both to the drinker, their families, and the people and community around them (Commonwealth of Australia 2019; NHMRC 2019). Alcohol consumption at harmful levels:

* contributes to violence within communities, and disability and death through accidents, assaults, suicide and homicide (AIHW 2020; Commonwealth of Australia 2019; Snijder et al. 2020). Alcohol consumption and family violence is discussed in section 4.12 *Family and community violence*.
* contributes to the burden of disease including alcohol use disorders, multiple types of cancer, chronic liver disease and cognitive impairment (Commonwealth of Australia 2019; Gao, Ogeil and Lloyd 2014).
* during pregnancy may cause physical and neurocognitive disorders termed ‘fetal alcohol spectrum disorders’ (Fitzpatrick et al. 2012; Gray et al. 2018). Alcohol consumption during pregnancy is discussed in section 6.2 *Health behaviours during pregnancy*.

People who engage in risky alcohol consumption, are not only at risk of harming themselves but also harming others. Research suggests that alcohol-related harm affects the population in different ways:

* women are more likely to be harmed by household members and relatives
* men are more likely to be harmed by friends, co-workers or strangers, and
* young people who drink are at an increased risk of harm, and young men are more likely to be harmed by their friends (Callinan and Livingstone 2019).

### Over one-quarter of Aboriginal and Torres Strait Islander adults abstain from alcohol, with the proportion in very remote areas significantly higher…

An increasing proportion of Aboriginal and Torres Strait Islander adults are abstaining from alcohol.[[5]](#footnote-5) In 2018‑19, 26 per cent of Aboriginal and Torres Strait Islander adults abstained, an increase from 23 per cent in 2012-13 (table 11A.1.1).

Aboriginal and Torres Strait Islander adults’ rates of abstinence are significantly higher in very remote areas. In 2018-19, the proportion of Aboriginal and Torres Strait Islander adults abstaining from alcohol in very remote areas (43 per cent) was twice the proportion for those in major cities (19 per cent) (table 11A.1.2).

A higher proportion of Aboriginal and Torres Strait Islander adults abstain from drinking alcohol than non-Indigenous adults. Nationally in 2017–19, after adjusting for differences in population age structures, the proportion of Aboriginal and Torres Strait Islander adults abstaining was 1.4 times the proportion of non-Indigenous adults abstaining (figure 11.1.1).

| Figure 11.1.1 **Adults abstaining from alcohol by remoteness area, by Indigenous status, 2017–19 (age-standardised rate)**a,b,c |
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| | Figure 11.1.1 Adults abstaining from alcohol by remoteness area, by Indigenous status, 2017–19 (age-standardised rate)  More details can be found within the text surrounding this image. | | --- | |
| a Error bars represent the 95 per cent confidence interval associated with each point estimate. b See table 11A.1.3-4 for detailed definitions, footnotes and caveats. c The total for non-Indigenous adults does not include very remote areas as data were not collected in these areas for non-Indigenous people. |
| *Source*: ABS (2019) *National Aboriginal and Torres Strait Islander Health Survey, 2018-19*, Cat. no. 4715.0, Canberra; tables 11A.1.3-4. |
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### … but some Aboriginal and Torres Strait Islander adults put themselves at risk of harm by exceeding alcohol consumption guidelines

High levels of alcohol consumption can increase the risk of lifetime harm. This happens when more than two standard drinks are consumed on average every day. Risky alcohol consumption can also occur on a single occasion, when more than four standard drinks are consumed.

The proportion of Aboriginal and Torres Strait Islander adults exceeding the alcohol consumption guidelines has remained stable for lifetime risk, but has increased slightly for single occasion risk. Nationally in 2018‑19, the proportion of Aboriginal and Torres Strait Islander adults who exceeded lifetime risk guidelines in the last week was 20 per cent (similar to 2012-13). The proportion exceeding the single occasion risk guidelines on at least one occasion in the previous 12 months decreased from 57 per cent in 2012-13 to 53 per cent in 2018-19, with this decrease driven by a decrease in those exceeding less often than once a week (the proportion exceeding less often than once a week decreased from 37 per cent to 34 per cent) (table 11A.1.1).

Men are more likely to exceed the risk guidelines for alcohol than women. For Aboriginal and Torres Strait Islander people aged 15 years or over in 2018-19, the proportion of males exceeding lifetime risk guidelines in the last week (28 per cent) was nearly three times the proportion of females (10 per cent) and the proportion of males exceeding single occasion risk guidelines on at least one occasion in the previous 12 months (61 per cent) was also significantly higher than the proportion of females (40 per cent) (table 11A.1.5).

After adjusting for differences in age structures, the proportions exceeding the alcohol consumption guidelines were higher for Aboriginal and Torre Strait Islander adults compared to non-Indigenous adults, except for the proportions exceeding the single occasion risk guidelines less often than once a week (both around 30 per cent) (table 11A.1.3).

Single occasion risky alcohol consumption is more prevalent amongst young people, especially after 18 years, once alcohol consumption is not prohibited. People that begin drinking hazardously at a young age are at increased risk of developing alcohol use disorders later in life (Freyer, Morley and Haber 2016). Aboriginal and Torres Strait Islander young adults are the age group with the highest proportion of those exceeding single occasion risk guideline at least once in the last year, with 65 per cent of young people aged 18–24 years and 62 per cent of young people aged 25–34 years old exceeding the guidelines at least once, compared to 54 per cent for all Aboriginal and Torres Strait Islander people aged 18 years or over (table 11A.1.6).

### How can the levels of risky alcohol consumption be reduced?

Risky alcohol consumption is associated with structural and individual risk factors. Most of the research that looks at how to address these factors and related harms does not specifically relate to Aboriginal and Torres Strait Islander people. However, the following approaches may be relevant.

* Restricting access to alcohol is one approach, noting that there can be unintended consequences with increases in ‘sly grog’ (Robertson, Fitts and Clough 2017). Restrictions can include the number of take away outlets (Smith et al. 2019) or by using liquor permits and alcohol management plans that determine the sale, timing and distribution of alcohol. These measures are in use in some, mainly Aboriginal, communities in WA, Queensland and the NT. The effectiveness of permits depends on the broader liquor management system including the agencies and procedures required to have a permit (d’Abbs and Crundall 2019)
* Reducing the demand for alcohol is another approach. This can be achieved by:
* inhibiting the appeal of alcohol — alcohol marketing and advertising has been found to induce young people to drink alcohol and engage in risky drinking (Jernigan et al. 2017) and to encourage young people under the age of 18 to drink (Sargent and Babor 2020)
* improving people’s mental wellbeing — alcohol use disorders[[6]](#footnote-6) often co-occur with mental health disorders (Freyer, Morley and Haber 2016; Wood et al. 2020) and people who die by suicide have a higher risk of an alcohol-use disorder at the time of death (Chong et al. 2020; Kolves et al. 2017). Mental health programs to improve mental wellbeing may have a role in reducing alcohol consumption
* engaging Aboriginal and Torres Strait Islander young people in education or employment through mentoring, sport or music programs provided by Aboriginal community controlled organisations may also reduce demand for alcohol and other drugs, however there is little research that provides evidence for this as an alcohol demand reduction strategy.

Culturally safe services or programs that are designed and implemented by Aboriginal and Torres Strait Islander people may deliver better outcomes in reducing risky alcohol consumption levels (Cass 2019; Gray et al. 2018; Harrison et al. 2019; Shanthosh et al. 2018). A global systematic review of Indigenous-led alcohol controls (including six Australian initiatives) concluded that these could be effective in improving health and social outcomes (Muhunthan et al. 2017). On the flipside, there is evidence that for some communities the impact of government policies and programs aimed at reducing alcohol consumption have had unintended (and negative) consequences (d’Abbs, Burlayn and Jamijin 2019; Robertson, Fitts and Clough 2017).

### Aboriginal and Torres Strait Islander people are overrepresented in hospitalisations and deaths from alcohol-related conditions

In line with the higher proportion of Aboriginal and Torres Strait Islander adults exceeding alcohol risk guidelines, Aboriginal and Torres Strait Islander people are overrepresented in hospitalisations from alcohol-related conditions, though at considerably lower numbers. In 2016–2018, after adjusting for differences in population age structures, the rate of alcohol‑related hospitalisations for Aboriginal and Torres Strait Islander people was almost four times the rate for non‑Indigenous people (table 11A.1.18). Putting this in context with those exceeding alcohol risk guidelines, the numbers of alcohol-related hospitalisations and deaths in 2016–2018 is less than 2 per cent of the number of people who exceeded the single occasion alcohol risk guidelines in 2018-19 (tables 11A.1.19 and 11A.1.5).

The main component of the higher hospitalisation rates of Aboriginal and Torres Strait Islander people from alcohol-related conditions is hospitalisations in remote areas for acute intoxication — in 2016–2018 this rate was almost twice the rate in 2010–2012, and is now 18 times the rate for equivalent non-Indigenous hospitalisations (table 11A.1.19).

Over the past 20 years, the age‑standardised rate of Aboriginal and Torres Strait Islander deaths related to alcohol has decreased, though is still around four times the rate for equivalent non-Indigenous deaths (table 11A.1.23). Liver diseases leading to cirrhosis are among the most common contributor to the mortality gap between Indigenous and other Australian adults (Valery et al. 2020). In 2014–2018, of the 467 deaths of Aboriginal and Torres Strait Islander people related to alcohol use, more than half were from alcoholic liver disease (table 11A.1.21). However, a decrease in hospitalisations for alcoholic liver disease is occurring (from an age standardised rate of 100 to 67 per 100 000 population) (table 11A.1.15).

People with alcohol use disorders tend to wait until significant harm to their health has occurred before they seek help, and Aboriginal and Torres Strait Islander people experience barriers which further delay the help they need, including racism, and a lack of culturally appropriate services and resources (Islam et al. 2018). This may mean that Aboriginal and Torres Strait Islander people are more likely to be hospitalised when their needs could have originally been met by a primary and community health service.

### Alcohol appears to be a contributing factor to homicides involving Aboriginal and Torres Strait Islander people as victim and offender

Nationally in 2017‑18, there were 196 homicide incidents resulting in 202 victims of homicide (section 4.12 *Family and community violence*, tables 4A.12.24 and 4A.12.26), of which the Indigenous status of victims and offenders were known in 167 incidents. Among these 167 incidents, 20 involved Aboriginal and Torres Strait Islander people as both victims and offenders. In 11 of these incidents (55 per cent), both the victim and offender had consumed alcohol at the time of the offence. In comparison, of the 135 homicide incidents involving only non‑Indigenous victims and offenders, 22 (16 per cent) involved both the victim and offender consuming alcohol (table 11A.1.24).

### Future directions in data

The NHMRC guidelines on which the indicator for alcohol consumption and harm is based are currently being reviewed. The draft guideline recommendations differ from the 2009 NHMRC guidelines and, if implemented, this will alter the comparability of historical 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[[7]](#footnote-7)

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| Box 11.2.1 Key messages |
| * Misuse of legal and illegal substances can negatively affect the lives of individuals, families and communities. Users are more susceptible to illness and accident, and injecting drug users who share needles are at a greater risk of blood‑borne diseases. * Illicit substance use often co-occurs with mental illness and psychological distress. It can contribute to the onset of, and prevent recovery from, mental illness and is a major risk factor for suicide. * The majority of Aboriginal and Torres Strait Islander adults do not illicitly use substances. In 2018-19, 70 per cent reported not illicitly using in the past 12 months. * But the proportion who report that they are illicitly using is increasing over time. Most illicit use is use of marijuana, hashish or cannabis resin (different forms of the cannabis plant), and its increase in recent years is driven by increases in regional and very remote areas. In 2018-19, there were no significant differences across remoteness areas. * In line with reported use, the proportion of drug-related hospitalisations has also increased over time — and more so for Aboriginal and Torres Strait Islander people than for non‑Indigenous people. * In 2018-19, more than half of all drug-related hospitalisations were related to mental and behavioural disorders. For Aboriginal and Torres Strait Islander people, this proportion was larger, at 60 per cent. * Responding to the needs of Aboriginal and Torres Strait Islander people who illicitly use substances requires an understanding of what is driving demand. It appears that there is limited research on this and, therefore, a lack of evidence on whether programs are effective in addressing the drivers of demand. * While reducing the supply of some substances can reduce illicit substance use, if the drivers of illicit use are not also addressed there can be unintended consequences (such as the use of alternative substances). |
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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. *Illicit use of* *substances* is defined as the proportion of adults who reported using illicit substances or misusing licit substances in the previous 12 months.[[8]](#footnote-8) Data are sourced from the ABS National Aboriginal and Torres Strait Islander Health Survey (NATSIHS)/National Aboriginal and Torres Strait Islander Social Survey (NATSISS), with the most recent available data for 2018‑19 from the NATSIHS (all jurisdictions; sex; age). Data were not available for remote areas in the 2004‑05 survey, or for non‑Indigenous people.  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).   Data on hospitalisations are from the AIHW National Hospital Morbidity Database.[[9]](#footnote-9) The latest data are for 2018-19. Data on deaths are from the ABS Causes of Death collection, and the latest data are for 2018. Data on homicides are from the Australian Institute of Criminology National Homicide Monitoring Program and the latest data are for 2017-18. |
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Misuse of legal and illegal drugs can negatively affect the lives of individuals, families and communities. People who misuse substances are more susceptible to illness (including mental illness — see section 8.7 *Mental health*) and accident, and injecting drug users who share needles are at a greater risk of blood‑borne diseases such as HIV and hepatitis (Baldock and Lindsay 2020; Teoh, Moses and McCullough 2019; Treloar, Mao and Wilson 2016).

Substance misuse is also a factor in suicide across the Australian population (Agrawal et al. 2017; Zahra et al. 2020), and specifically for Aboriginal and Torres Strait Islander people (Dickson et al. 2019). A study of a group of Aboriginal and Torres Strait Islander prisoners in Queensland found that mental illness and lifetime suicide thoughts and attempts were significantly more likely among those with a substance use disorder (Heffernan et al. 2016). Suicide and self-harm are discussed in section 8.8 *Suicide and self-harm*.

Illicit substance use by parents can affect children both pre- and post‑birth. Pregnant women who take drugs can affect the health and wellbeing of their unborn children, and some babies are born with addiction issues. Prenatal exposure to volatile substances (when people deliberately inhale chemical vapours to produce altered states) can lead to birth prematurity, delays in development, neuro-behavioural problems and physical malformations (Marel, MacLean and Midford 2015). And parents who misuse substances can find caring for children more difficult. Use of illicit substances during pregnancy and when caring for children is discussed in section 6.2 *Health behaviours during pregnancy* and section 4.11 *Substantiated child abuse and neglect*.

Illicit substance use is often associated with crime (and therefore imprisonment) and violence (from methamphetamine users in particular) (Goldsmid and Willis 2016; Macrae and Hoareau 2016; Marel, MacLean and Midford 2015). Use of illicit substances is also discussed in section 4.12 *Family and community violence*.

### Most Aboriginal and Torres Strait Islander adults do not illicitly use substances, but use of marijuana, hashish and cannabis is increasing…

Most Aboriginal and Torres Strait Islander adults do not illicitly use substances. In 2018-19, 70 per cent of Aboriginal and Torres Strait Islander adults reported not illicitly using substances in the last 12 months (table 11A.2.1). For those illicitly using substances, the use occurs most commonly in young adult men. For Aboriginal and Torres Strait Islander men aged 25–34 years, half reported illicitly using substances in the last 12 months (table 11A.2.6).

The majority of illicit substance use (around 85 per cent) is of marijuana, hashish or cannabis resin (table 11A.2.1). The proportion of Aboriginal and Torres Strait Islander adults illicitly using these substances has increased over time: it was around 18–20 per cent from 2002 to 2014-15, before increasing to 24 per cent in 2018-19 (table 11A.2.3). This increase has been driven by increasing proportions of users in regional and very remote areas in the last four years (figure 11.2.1).

### … and hospitalisations and deaths from drug-related issues are also increasing

While the rate of drug-related hospitalisations has increased for all Australians over the past decade, it has increased more for Aboriginal and Torres Strait Islander people. The rate of drug‑related hospitalisations for Aboriginal and Torres Strait Islander people has more than doubled (from 391 per 100 000 population in 2010-11 to 777 per 100 000 population in 2018‑19), compared with a 20 per cent increase for non-Indigenous people. After adjusting for differences in population age structures, the drug-related hospitalisation rate for Aboriginal and Torres Strait Islander people was more than three times the rate for   
non-Indigenous people (up from a ratio of around 2:1 in 2010-11) (table 11A.2.8).

Around half of all drug-related hospitalisations for non-Indigenous people are related to mental and behavioural disorders (the remainder are related to poisoning, including accidental poisoning, and other). But for Aboriginal and Torres Strait Islander people this proportion is larger, at 60 per cent. In 2018-19, after adjusting for population age structures, Aboriginal and Torres Strait Islander people were hospitalised for drug-related mental and behavioural disorders at four times the rate of non-Indigenous people (table 11A.2.8).

| Figure 11.2.1 Marijuana, hashish or cannabis resin use for Aboriginal and Torres Strait Islander adults, by remoteness, by year**a,b,c** |
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| | Figure 11.2.1 Marijuana, hashish or cannabis resin use for Aboriginal and Torres Strait Islander adults, by remoteness, by year  More details can be found within the text surrounding this image. | | --- | |
| a Error bars represent the 95 per cent confidence interval associated with each point estimate. b See  table 11A.2.3 for detailed definitions, footnotes and caveats. c Data are not available for remote and very remote areas in 2004-05. |
| *Source*: ABS (unpublished) National Aboriginal Torres Strait Islander Health Survey (various years); table 11A.2.3. |
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The increase in the rate of drug-related hospitalisations is seen across all remoteness areas and for all people, but is more pronounced for Aboriginal and Torres Strait Islander people in major cities and regional areas (table 11A.2.11).

Drug-induced deaths[[10]](#footnote-10) have also increased for both Aboriginal and Torres Strait Islander and   
non-Indigenous people. In 2014−2018, after adjusting for differences in population age structures, the drug‑induced death rate for Aboriginal and Torres Strait Islander people was around twice the rate for non‑Indigenous people, up from a ratio of 1.6:1 in 2009−2013 (table 11A.2.14). The largest increase in the age-standardised rate over this period was for Aboriginal and Torres Strait Islander males (from 12 to 17 per 100 000 population) (table 11A.2.14).

Data on drug involvements in homicides are included in table 11A.2.15. The number of Aboriginal and Torres Strait Islander homicide incidents and the influence of drugs on the victims and/or offenders are small and difficult to interpret. Numbers have fluctuated, with no clear trend over the period 1999‑2000 to 2017‑18.

### More evidence is required on the drivers of use to effectively respond

Responding to the needs of Aboriginal and Torres Strait Islander people who illicitly use substances requires an understanding of what drives demand, but the evidence on this is sparse (see Leske et al (2016) and Snijder et al (2020)[[11]](#footnote-11)). For example, one study on cannabis use found that peers potentially had an impact on use (Geia et al. 2018; Intergovernmental Committee on Drugs 2014), while another found that use was linked to perceived calming or self-regulating benefits (Graham and Clough 2019). But these findings do not explain what the underlying drivers are that make a person more likely to be influenced by peers, or why they need a substance to calm them.

When Aboriginal and Torres Strait Islander people use substances for relief, this must be considered within the context of trauma and its continuing intergenerational impacts as a result of colonisation, dispossession and economic exclusion (Calma, Dudgeon and Bray 2017; Macrae and Hoareau 2016). For example, in research on Aboriginal use of methamphetamine, participants identified historical trauma, contemporary disadvantage and racism, along with incarceration and other social factors (such as those related to education, employment and housing) as the cause of the market for ice and other drugs within Aboriginal and Torres Strait Islander communities (MacLean, Hengsen and Stephens 2017; Snijder and Kershaw 2019).

A recent study of a residential drug and alcohol treatment program for young Aboriginal and Torres Strait Islander people found that culturally relevant modes of treatment, and taking a harm-minimisation and holistic approach to the factors in the young person’s life, saw a reduction in the levels of self-harm, substance misuse, and arrests (Nathan et al. 2020).

In addition to addressing the demand for substances, there is also a need to reduce the supply of substances for illicit use. But unintended consequences, such as the use of replacement substances, need to be considered. For example, the Government replaced regular unleaded petrol with low aromatic fuel in a number of regional and remote locations, which significantly reduced petrol sniffing; however, some petrol sniffers have moved to alcohol or cannabis instead (d’Abbs et al. 2019).

### Future directions in data

Data on illicit substance use in Australia are based on self-reported survey data. The data may under-estimate consumption, because these drugs are illegal to possess (Macrae and Hoareau 2016) and this may affect respondents’ willingness to respond honestly. Results of previous ABS surveys and administrative data collections on the 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. The National Aboriginal and Torres Strait Islander Peoples’ Drug Strategy 2014–2019 (Intergovernmental Committee on Drugs 2014) prioritises the establishment of meaningful performance measures with effective data collection to support community-led monitoring and evaluation. Given the rise in cannabis use in conjunction with tobacco by Aboriginal and Torres Strait Islander young people, data to support an understanding of this mix would be useful.

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## 11.3 Youth diversions[[12]](#footnote-12)

| Box 11.3.1 Key messages |
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| * Youth diversion provides an opportunity for the criminal justice system to identify and respond to the complex needs of young people so that they are prevented from entering and re-entering the system, which can fundamentally change their life trajectory. * Aboriginal and Torres Strait Islander young people are less likely to be diverted than non‑Indigenous young people. Rates of diversions for Aboriginal and Torres Strait Islander young people were between 39 and 88 per cent of the rates for non-Indigenous young people. * Data are not comparable across states and territories, but for most jurisdictions the average diversion rate for Aboriginal and Torres Strait Islander and non-Indigenous young people over the last four years (2015-16 to 2018-19) was lower or the same as in the preceding four years (2010-11 to 2014-15), indicating a trend nationally towards less diversion. * Aboriginal and Torres Strait Islander young people are more likely to have various risk factors, which therefore contribute to lower rates of diversion for them. Personal risk factors include cognitive and intellectual impairment, poor mental health, and previous negative experiences (for Aboriginal and Torres Strait Islander young people or their families) with police. Structural risk factors include a lack of supports for children who are in out-of-home care or homeless, a lack of diversionary programs in rural and remote areas, and mandatory sentencing. * For police services specifically, evidence suggests that race may be a factor in decisions to approach individuals before an offence has occurred. Past negative experiences between Aboriginal and Torres Strait Islander people and police may lead some Aboriginal and Torres Strait Islander young people to be less willing to cooperate, which would in turn contribute to lower rates of diversion. * Increasing diversion rates for Aboriginal and Torres Strait Islander young people will involve addressing personal and structural risk factors and the way in which police deal with these young people. Diversionary programs and approaches to increasing diversion rates for Aboriginal and Torres Strait Islander young people need to be designed and implemented by (or with) Aboriginal and Torres Strait Islander people to be most beneficial. |
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| Box 11.3.2 Measures of youth diversions |
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| There is one main measure for this indicator. *Youth 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). These data do not include young people who are diverted by a court.  State and Territory governments are responsible for youth diversions (and table 11A.3.1 outlines the relevant legislation for each jurisdiction). Differences in programs and data collection mean that data are not comparable across jurisdictions.  The most recent available data are for 2018-19 (or the 2019 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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Youth diversion programs are designed for young people with little or no history of offending who are alleged to have committed non-serious crimes. Diversion can prevent young people from entering the criminal justice system or getting a criminal record, and can also lead to lower rates of reoffending (particularly for minor offences) (Shirley 2017; Wang and Weatherburn 2019).

Diversion can save money and deliver better social outcomes (Shanahan, Hughes and McSweeney 2017). Diversion is also an opportunity to identify the many complex needs of each offender (such as family, behavioural and health problems including substance use), and to connect the alleged offender with services that will support young people.

Diversion can occur at any point following initial contact with police — pre‑arrest, pre‑trial, pre‑sentence, post‑sentence and pre‑release. While ‘diversion’ describes 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).

Diversions with 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 are all required for a diversion to occur (Allard et al. 2010).

### While youth diversion data are not comparable across states and territories, some of the key findings are similar

Governing legislation and the scope of youth diversions differ significantly across states and territories (table 11A.3.1) — as do diversionary programs. Diversionary programs can include opportunities for the alleged young offender to take responsibility for their actions, understand the harm their actions have caused, engage in restorative justice, or receive case management and support. As a result, data for youth diversion are not comparable across states and territories. However, the key findings across states and territories are similar and include that:

* Aboriginal and Torres Strait Islander young people were less likely to be cautioned or diverted out of the criminal justice system than non-Indigenous young people. For the most recent year of reporting, rates of diversion were between two-fifths (39 per cent) and nine-tenths (88 per cent) of the rates for non-Indigenous young people (table 11A.3.2)
* the diversion rates for both Aboriginal and Torres Strait Islander and non-Indigenous young people have fluctuated over time, but the average over the last four years (2015‑16 to 2018‑19) was lower or the same as for the previous four years (2011-12 to 2014‑15) — this was the case for all jurisdictions except young people in SA and the NT, Aboriginal and Torres Strait Islander young people in WA, and non-Indigenous young people in NSW and the ACT, for whom diversion rates have gone up (table 11A.3.2)
* the most common types of offence category for which both Aboriginal and Torres Strait Islander and non-Indigenous young people were diverted (broadly grouped according to crimes against the person, crimes against property, drug offences and other offences) were crimes against property or theft (tables 11A.3.5, 11A.3.8, 11A.3.25, 11A.3.39, 11A.3.41 and 11A.3.57), while the offence category for which diversion was least common for Aboriginal and Torres Strait Islander young people was drug offences.

Lower rates of diversion for Aboriginal and Torres Strait Islander young people could be one reason why they are overrepresented in the criminal justice system.

### What factors affect the rates of youth diversions for Aboriginal and Torres Strait Islander young people?

A range of personal and structural risk factors affect the rates of diversion, and many of these disproportionately affect Aboriginal and Torres Strait Islander young people.

* Young people who are homeless or in out-of-home care are more likely to offend, and also more likely to experience custodial remand rather than diversion (McFarlane 2018; Sentencing Advisory Council 2020). (See section 4.11 *Substantiations for child abuse and neglect*.) Diversion may not be accessible for young people who are homeless or in out-of-home care if the diversion program requires participation by family members, such as in a family group conference, and the relationship with (or absence of) a caregiver does not provide the required level of support.
* Young people with cognitive or intellectual impairments or mental health issues are more likely than their peers to be arrested and less likely to be considered for diversion (Blagg, Tulich and Bush 2017). For many of these youth, diversionary programs are necessary to avoid indefinite detention when they are found unfit to stand trial (Blagg and Tulich 2018).
* Access to diversion programs can be limited in some rural and remote areas. The range of diversion options and referral processes differs across states and territories, and in some areas young people do not have access to diversion (Green et al. 2016). As a consequence of the lack of diversion programs in rural and remote areas, Aboriginal and Torres Strait Islander young people may be more likely to be detained (Papalia et al. 2019).
* Mandatory sentencing means that options are limited if an alleged offender has committed a particular crime on several occasions. Mandatory sentencing will disproportionately affect Aboriginal and Torres Strait Islander offenders, as they are more likely to be charged for offences that have mandatory sentences attached (ALRC 2017).

Furthermore, youth diversion conferencing may be less effective in reducing recidivism for Aboriginal and Torres Strait Islander young people if not undertaken as part of a holistic approach. This is because restorative justice approaches (such as in youth diversion conferencing) tend to elicit accountability through ‘shaming’ but do not address the risk factors associated with youth offending, such as substance use and low socioeconomic status (Little, Stewart and Ryan 2018). However, there is little research that explores the effectiveness of youth diversion conferencing for Aboriginal and Torres Strait Islander young people.

The extent to which diversionary outcomes reflect institutional racism has not been evaluated. However, as it is primarily police who assess young people and determine their eligibility for pre-court diversion (Green et al. 2020), past negative experiences between Aboriginal and Torres Strait Islander people and police, compounded by policing practices that can be racialised (such as stop and search or move on powers where no offending behaviour is apparent) can mean that Aboriginal and Torres Strait Islander young people may feel harassed or threatened (Cunneen 2019). In these circumstances, these young people may be less willing to cooperate, and this can in turn prevent police from considering diversion as an option (Blagg and Anthony 2020; Papalia et al. 2019).

### How can diversion rates for Aboriginal and Torres Islander young people be increased?

Given the factors leading to the lower rates of diversion outlined above, strategies for increasing the diversion rates for Aboriginal and Torres Strait Islander young people may include:

* designing and implementing diversion programs that address the particular needs of young people who are homeless or in out-of-home care, and at risk of transitioning to juvenile justice, so that they are not unfairly treated by the criminal justice system (see Barreng Moorop, for example, in JSS 2018)
* building the cultural competency of police in relating to Aboriginal and Torres Strait Islander young people (Coffin, Kennedy and Owen 2018), including that the policies relating to police practice are responsive to local communities and contexts (Fleming in Putt 2010, p. 4)
* providing families with Aboriginal and Torres Strait Islander children who are in or at risk of entering the criminal justice system with the support they need to interact with and navigate the system (including accessible and culturally appropriate legal advice) (DHHS 2020).

Incorporating elements into youth diversion programs that address the risk factors for Aboriginal and Torres Strait Islander youth offending, such as illicit substance use, poor impulse control and childhood trauma, may increase the programs’ effectiveness in reducing repeat offending (Little, Stewart and Ryan 2018). And more evaluation of programs to assess their effectiveness is needed.

To ensure that youth diversion programs or approaches for Aboriginal and Torres Strait Islander young people are as beneficial as possible, they need to be designed and implemented by (or with) Aboriginal and Torres Strait Islander people (Blagg, Tulich and Bush 2017).

### Future directions in data

Nationally comparable and complete data on youth diversions are not available, and have not been available over the two decades of this Report. 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.

To assist in explaining the differences in diversion rates between Aboriginal and Torres Strait Islander and non-Indigenous youth, information is also required on why alleged offenders were denied diversion (for example, not meeting eligibility criteria, unavailability of diversion programs and/or declining to participate in diversion).

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## 11.4 Repeat offending[[13]](#footnote-13)

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| Box 11.4.1 Key messages |
| * While most Aboriginal and Torres Strait Islander people do not have contact with the justice system, the higher rates of incarceration among Aboriginal and Torres Strait Islander people compared to non-Indigenous people are strongly linked to higher rates of repeat offending. * Aboriginal and Torres Strait Islander youth enter the criminal justice system at a younger age than non‑Indigenous youth, which is a factor in their rates of return. * Of all young people under sentenced supervision in 2018-19 and for whom their first supervision was at 10–13 years of age, 70 per cent were Aboriginal and Torres Strait Islander. Over the period 2000-01 to 2018-19, 55 per cent of Aboriginal and Torres Strait Islander young people in sentenced supervision had more than one supervised sentence, compared to 34 per cent for non‑Indigenous young people. * The proportions of adult prisoners with prior adult imprisonment have increased for both Aboriginal and Torres Strait Islander and non-Indigenous prisoners. In 2019, 78 per cent of Aboriginal and Torres Strait Islanders prisoners had known prior adult imprisonment compared to 50 per cent of non‑Indigenous prisoners, a ratio of 1.5 that has remained relatively unchanged for the last 20 years. * Risk factors that disproportionately affect Aboriginal and Torres Strait Islander people relative to non‑Indigenous people and contribute to their overrepresentation in return to supervision and re‑incarceration include: * experience prior to prison * the higher prevalence of personal and situational risk factors for offending behaviours such as unstable housing, substance abuse and involvement with child protection services * institution and structural risk factors, from within and outside the criminal justice system * prison-life and post-prison experiences * limited culturally safe prison programs to address offending behaviours (including through healing past traumas) * lack of support services to facilitate transition back into the community on release. * For prisons, there is evidence that re-incarceration of Aboriginal and Torres Strait Islander prisoners may be reduced through prison-provided support programs that are accessible, culturally safe, trauma-informed and: * have been developed and delivered by Aboriginal and Torres Strait Islander people * extend beyond the prison environment to combine with health, legal and family support services. * Enabling prisoners to remain connected with their community while in prison, such as through prison visits, can also reduce the risk of re-offending and re-incarceration. |
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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. The data for this section focuses on the re‑incarceration aspect of repeat offending. There are two main measures for this indicator:   * *Adult re‑incarceration* 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 prior adult imprisonment under sentence are from the ABS Prisoners in Australia collection for 30 June 2019 (all jurisdictions; sex). The most recent available data for young people returning to sentenced youth justice supervision are from the AIHW’s Juvenile Justice National Minimum Dataset 2018-19 (national).  A supplementary measure of the proportion of offenders who were proceeded against by police is also reported (NSW, Queensland, SA, ACT and the NT; age; sex). |
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Repeat offending, or recidivism, refers to repetitious criminal activity. Repeat offending is difficult to measure accurately, as offences are not always detected or recorded by police, and court convictions do not necessarily result in contact with corrective services. Consequently, repeat offending is often defined as re‑apprehension (in relation to police), re‑conviction (in relation to courts) or re‑incarceration (in relation to youth detention and adult imprisonment).

While most Aboriginal and Torres Strait Islander people do not come into contact with the justice system, the small proportion who do contribute significantly to the overrepresentation of Aboriginal and Torres Strait Islander people in the criminal justice system due to the high rates of repeat offending (AIHW &AIFS 2013; Snowball and Weatherburn 2006). Aboriginal and Torres Strait Islander youth are incarcerated at about 22 times the rate of non-Indigenous youth, and for adults it is about 12 times the rate of non-Indigenous adults (section 4.13 *Imprisonment and youth detention*).

Reducing re-incarceration is particularly important as prison has a significant impact on the lives of those who experience it, their families and communities. While imprisonment leads to social exclusion of people from their communities, repeat imprisonment further exacerbates this (Schwartz 2010), and the disadvantage ex-prisoners and their families often already experience. Their ongoing absence affects the family’s ability to function without a breadwinner, without a parent or carer, and the role they had in the wider community.

While these issues are not unique to Aboriginal and Torres Strait Islander people they disproportionately affect them, as they combine with the other disadvantages they experience (at a greater rate than non-Indigenous people). Incarceration is a stronger predictor of the risk of future incarceration for Aboriginal and Torres Strait Islander people than it is for non‑Indigenous people (Ryan et al. 2019; Wundersitz 2010).

### Aboriginal and Torres Strait Islander youth enter the criminal justice system at a younger age than non-Indigenous youth, which is factor in their return

People first enter the justice system when they are investigated by police for allegedly committing an offence. At this time, police can warn the alleged offender, or they may be proceeded against via court or non‑court actions. An offender can be proceeded against by police[[14]](#footnote-14) multiple times during a given period.

Aboriginal and Torres Strait Islander young offenders are proceeded against by police at a younger age than non-Indigenous offenders. In 2018-19 for jurisdictions with available data, the ratio of Aboriginal and Torres Strait Islander to non-Indigenous young offenders aged 10–14 years who were proceeded against varied. In the ACT, the rates were similar, and in the NT the rate of Aboriginal and Torres Strait Islander young offenders aged 10–14 years who were proceeded against was five times the rate of non‑Indigenous young offenders (table 11A.4.6). Research indicates some level of structural and institutional racism and bias (unconscious or otherwise) in Australian police services (Dwyer 2018; Harvey 2012; OPI 2011) which may explain some of the disparity between rates of being proceeded against by police for Aboriginal and Torres Strait Islander and non‑Indigenous people.

Consistent with the age difference above for police apprehensions, Aboriginal and Torres Strait Islander young people enter their first period of sentenced supervision (detention or community-based supervision) at a younger age than non-Indigenous young people[[15]](#footnote-15). In 2018-19, of those under sentenced supervision, 70 per cent of those whose first supervision was at ages 10–13 years were Aboriginal and Torres Strait Islander youth (AIHW 2020b).

The younger the age, the greater the proportion returning to sentenced supervision. Of sentenced children aged 10–12 years, 90 per cent of those whose first sentence was community-based returned to sentenced supervision, and 94 per cent of those whose first sentence was detention returned to sentenced supervision before the age of 18 years (AIHW 2020a). So, unsurprisingly, the rate of return to sentenced supervision is higher for Aboriginal and Torres Strait Islander youth compared to non-Indigenous youth. From 2000‍‍‍‑01 to 2018-19, 55 per cent of Aboriginal and Torres Strait Islander young people in sentenced supervision had more than one supervised sentence, compared to 34 per cent for non-Indigenous young people (table 11A.4.3).

Within a 12-month period, the rate of return to detention is within six percentage points for Aboriginal and Torres Strait Islander youth and non-Indigenous youth (79 per cent and 75 per cent respectively for detainees returning 12 months after release in 2017‑18, and 35 and 30 per cent for those released from community-based supervision) (table 11A.4.4).

### Aboriginal and Torres Strait Islander adult prisoners have higher rates of prior imprisonment compared with non-Indigenous prisoners

In 2018‑19 for jurisdictions with available data, 38 to 50 per cent of Aboriginal and Torres Strait Islander offenders were proceeded against by police on more than one occasion, compared with 16 to 34 per cent of non‑Indigenous offenders (table 11A.4.5). (While available data on the number of times an offender was proceeded against does not include their age, the data reported by age (table 11A.4.6) shows that around 80 per cent of offenders proceeded against were aged 20 years or over, indicating that the all age population is sufficiently representative of the adult population.)

At 30 June 2019, 78 per cent of Aboriginal and Torres Strait Islander adult prisoners nationally had a known prior adult imprisonment. This proportion has changed little over the past 20 years (table 11A.4.1). Having a known prior imprisonment can significantly increase the risk of further incarceration, by up to 2.7 times that of a first-time prisoner (Ryan et al. 2019). Aboriginal and Torres Strait Islander prisoners are more likely than non‑Indigenous prisoners to have been in prison before. At 30 June 2019, the proportion of Aboriginal and Torres Strait Islander prisoners with prior imprisonment was 1.5 times the proportion for non‑Indigenous prisoners. This ratio has remained relatively constant over the past 20 years.

National data are not available by Indigenous status on the proportion of adults who leave prison and are re-incarcerated (the above data relate to only those re-incarcerated). However, a study of Queensland adult ex-prisoners found a similar gap in re-incarceration rates across Aboriginal and Torres Strait Islander and non-Indigenous ex-prisoners (Ryan et al. 2019).

### Why are rates of return to the criminal justice system higher for Aboriginal and Torres Strait Islander offenders than for non-Indigenous offenders?

Higher rates of repeat offending, as measured by repeat police apprehension, return to supervision or return to prison, for Aboriginal and Torres Strait Islander people are in part due to the reasons they are more likely to be incarcerated in the first place (see section 4.13 *Imprisonment and youth detention*), including:

* higher prevalence of personal and situational risk factors – these factors include younger age profile (younger people have a higher risk of incarceration), cognitive impairment (offenders with cognitive impairment are almost three times as likely to reoffend than those without) (Shepherd et al. 2017), unstable housing, substance abuse, family problems, child protection involvement, peer delinquency and school related problems (Lind 2011; Ringland, Weatherburn and Poynton 2015; Ryan et al. 2020; Shepherd et al. 2017)
* structural and systemic issues — such as the lack of access to affordable justice services, lack of access to secure accommodation that is a disadvantage when applying for bail, and lack of non-custodial sentencing options in some areas, which all disproportionately affect Aboriginal and Torres Strait Islander people (ALRC 2017; Schwartz 2010).

These higher rates for Aboriginal and Torres Strait Islander offenders can also be explained in part by their treatment in prisons and on their release. The prison environment (the social, emotional, organizational and physical characteristics of a correctional institution) can support or hinder a prisoners’ rehabilitation and reduce re-offending (Hall and Chong 2018) or they may be mistreated and, in the worst case, die (Commonwealth of Australia 2017; RCADIC 1991). While Australian prisons are well equipped to meet the non‑criminogenic needs of most offenders, they may be less well equipped to support prisoners with other needs that are associated with re-offending and which are more likely to affect Aboriginal and Torres Strait Islander prisoners, including:

* psychological distress and mental health disorders (including healing for past trauma)
* substance abuse
* poor treatment adherence and threatening behaviours (Ryan et al. 2019; Shepherd et al. 2018; Shepherd, Ogloff and Thomas 2016).

Enabling prisoners to remain connected with their community while in prison, such as through prison visits, can also reduce the risk of re-offending and re-incarceration (Lafferty et al. 2016; Ryan et al. 2020). It is particularly important for Aboriginal and Torres Strait Islander young people as connection with community is a key part of their culture and healing (Government of South Australia 2020), and due to other factors the connection may be more difficult to maintain. For example, the more times a prisoner has been incarcerated, the less likely they are to be visited, and travel distance also decreases the likelihood of visitation. For these, and other reasons, Aboriginal and Torres Strait Islander people may be unable to maintain their community connections as readily as they would have outside of prison or to the same extent as non-Indigenous people (Ryan et al. 2020).

The lack of suitable support available for ex-offenders to re-integrate them back into community is also a factor in re-offending (Abbott et al. 2018; Standing Committee on Social Issues 2008) and these supports are likely to be needed by Aboriginal and Torres Strait Islander people more than non-Indigenous people, due to their pre-existing disadvantage. For example, suitable housing and employment are vital factors in social re‑integration — people leaving prison may experience distrust by employers and rental agents (Baldry et al. 2006; Dawes et al. 2017; Ryan et al. 2019, 2020), and if this disadvantage is overlaid with racism they will have great difficulties finding employment and housing. Common reasons for Aboriginal and Torres Strait Islander prisoners returning to custody, in addition to breaching parole conditions, are unsupported health needs, lack of employment, lack of housing, substance abuse and domestic violence (Apted, Hew and Sinha 2013; Shepherd, Ogloff and Thomas 2016).

### How can the cycle of reoffending and return to custody be broken for Aboriginal and Torres Strait Islander people?

Along with addressing the personal, structural and systemic risk factors that lead Aboriginal and Torres Strait Islander people to enter detention (prison) or supervision more regularly than non-Indigenous people in the first place (see section 4.13 *Imprisonment and youth detention*), the keys to reducing the overrepresentation of Aboriginal and Torres Strait Islander people in detention (prison), are by focussing on:

* rehabilitation (including healing for childhood trauma) while they are in prison
* including prisoners on remand in programs
* helping them integrate back into their communities.

In contrast to the factors that lead to supervision, incarceration (see section 4.13 *Imprisonment and youth detention*) and re-incarceration, a range of protective factors can influence the experience of Aboriginal and Torres Strait Islander prisoners in custody and their prospects when they are released. If programs are provided in prison or youth detention, that effectively address offending behaviours (including through addressing childhood trauma), rehabilitate, support and prepare people for release, the risk of repeat offending may be reduced — for example, programs that address mental health disorders and cognitive impairment and meet their complex support needs (McCausland, McEntyre and Baldry 2017). These programs need to be accessible, trauma-informed, culturally safe, developed and delivered by Aboriginal and Torres Strait Islander people, extend beyond the prison environment, and be combined with strong health, legal and family support services (ALRC 2017; Ryan et al. 2019; Shepherd, Ogloff and Thomas 2016).

Further work is needed to understand which programs will best support the wellbeing of Aboriginal and Torres Strait Islander people in prison. A recent systematic review of colonised countries (including Australia) found a lack of quality evidence on what works in prisons, noting ‘there is a moral, social and practical imperative to build a strong evidence base on this topic’ (Perdacher, Kavanagh and Sheffield 2019). However, the study did note that despite the limited evidence, culturally-based interventions delivered or supported by indigenous facilitators appeared to have potential for increased recovery from trauma, reduced alcohol‑related problems and lower reoffending.

For Aboriginal and Torres Strait Islander people leaving prison, culturally safe programs to re-integrate them into community are also important (Dawes and Davidson 2019) as are programs that are accessible and timely and which address the living experience of those about to leave prison (Sheehan 2019). Seeking solutions to criminal offending outside the penal system, supporting and strengthening communities to address the social and economic causes of crime and considering alternatives to imprisonment for minor offences (Schwartz 2010) are also key to breaking the cycle of repeat offending, and justice reinvestment may also be a way of doing this (Dawes and Davidson 2019). Other approaches are discussed in section 4.13 *Imprisonment and youth detention*.

### Future directions in data

The Australian Bureau of Statistics is working with corrective services agencies to explore ways to improve adult prisoner flow data to build a more accurate picture of incarceration.

The data for adults and youth are not directly comparable, as data for adults are limited in scope to those that have returned to prison. Data on the proportion of adult prisoners who are released and returned to prison or community corrections within two years of release (sourced from corrective services agencies) are available, but the data are not disaggregated by Indigenous status. This disaggregation would provide a useful comparison with youth detention data.

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## 11.5 Community functioning[[16]](#footnote-16)

| Box 11.5.1 Key messages |
| --- |
| * Community functioning is defined in the Aboriginal and Torres Strait Islander Health Performance Framework (ATSIHPF) 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. * Research shows that community functioning is strongly associated with individual wellbeing and that individuals with high levels of connectedness, resilience and safety were more likely to be satisfied with their life, and to be generally happier. * Themes important to community functioning are: connectedness to Country, lands 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. * Aboriginal and Torres Strait Islander people’s understandings of community and community functioning may differ from Western or policy-centred understandings which are confined to a geographic area. Rather, their understandings of ‘community’ may be defined in terms of the metaphysical, geophysical or biophysical, and across generations. |
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| Box 11.5.2 Measures of community functioning |
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| 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). There are no new data available for this report. 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, in the Aboriginal and Torres Strait Islander Health Performance Framework (ATSIHPF), is defined as ‘the ability and freedom of community members and communities to determine the context of their lives and to translate capability into action’ (AHMAC 2017). The conversion of capabilities into functioning is influenced by the values, and personal characteristics of individuals, along with families and communities, and the environments in which they live. Different cultures will give greater or lesser priority to different aspects of functioning, and Aboriginal and Torres Strait Islander people’s understandings of community, and community functioning may differ from Western understandings which are service or policy-oriented (Taylor et al. 2011). For example, Aboriginal and Torres Strait Islander people’s understandings of community may not be place-based or confined to a geographic area but, instead, be defined in terms of the metaphysical, geophysical or biophysical, and across generations; identities that are made up of the land-sea-spirit, cultures, and people (Taylor et al. 2011).

Workshops led by Aboriginal facilitators, on behalf of the work program for the ATSIHPF report, developed the concept of community functioning with Aboriginal and Torres Strait Islander people 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 people. The information presented here aligns with that in the ATSIHPF report.

Research shows that community functioning is strongly associated with individual wellbeing, and that individuals with high levels of connectedness, resilience and safety were more likely to be satisfied with their life, and to be generally happier (Biddle 2017).

### Findings for community functioning themes

A summary of key findings using data from the 2014-15 NATSISS, which is an individual‑level survey, 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 tables 11A.5.2–4 for 2014-15 and tables 11A.5.5-6 for 2008.

#### Connectedness to Country, lands and history, culture and identity

Nationally, in 2014-15, for Aboriginal and Torres Strait Islander people:

* 74 per cent recognised their traditional lands, similar to 72 per cent in 2008. A higher proportion of Aboriginal and Torres Strait Islander people in remote (84 per cent) and very remote (91 per cent) areas recognised their traditional lands compared with those in major cities (67 per cent)
* 62 per cent identified with a clan or language group, similar to in 2008
* 95 per cent had contact with family or friends outside the household at least once per week (similar to 2008) and 82 per cent had friends to confide in
* 90 per cent felt able to have a say with family and friends, some or more of the time. The proportion of Aboriginal and Torres Strait Islander people who felt able to have a say ranged from 91 per cent in major cities to 84 per cent in very remote areas (tables 11A.5.1–2).

Refer to sections 5.1 *Valuing* *Aboriginal and Torres Strait Islander people and their cultures*, 5.7 *Participation in community activities* and 5.8 *Access to traditional lands and waters* for further information.

| 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 | | **Vitality** (10 per cent) | * Community infrastructure * Access to services * Education * Health * Income * Employment | |
| *Source*: AHMAC (2015) *Aboriginal and Torres Strait Islander Health Performance Framework 2014 Report*, Canberra. |
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#### Resilience

Nationally, in 2014-15, for Aboriginal and Torres Strait Islander people:

* 86 per cent did not avoid situations due to past unfair treatment
* 89 per cent felt they were able to find general support from outside the household
* 59 per cent had provided support to someone outside their household in the last month
* 81 per cent agreed that their doctor could be trusted, and 70 per cent agreed that the local school could be trusted. A higher proportion of Aboriginal and Torres Strait Islander people in remote areas (73 per cent) and very remote areas (82 per cent) had trust in their local school, compared with people in major cities (68 per cent). There were no significant differences for trust in doctors across regions
* 20 per cent had involvement with an Aboriginal or Torres Strait Islander organisation, similar to in 2008
* 97 per cent of adults participated in sport/social/community activities in the past 12 months (tables 11A.5.1-2).

Refer to sections 5.1 *Valuing Aboriginal and Torres Strait Islander* *people and their cultures* and 5.7 *Participation in community activities* for further information.

#### Leadership

Nationally, in 2014-15, for Aboriginal and Torres Strait Islander people:

* 44 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 people:

* 77 per cent had lived in only one dwelling in the last 12 months or longer
* 96 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 people:

* 78 per cent had not experienced physical and/or threatened violence in the last 12 months, similar to 2008
* 84 per cent felt safe at home alone after dark
* 54 per cent of children aged 2–14 years were taught Indigenous cultures at school
* 97 per cent had not been incarcerated in the last five years (and 91 per cent had never been incarcerated in their lifetime) (table 11A.5.1).

#### Vitality

Nationally, in 2014-15, for Aboriginal and Torres Strait Islander people:

* 55 per cent had no disability or (restrictive) long-term health condition
* 66 per cent had a low/moderate level of psychological distress
* 72 per cent lived in a dwelling that had no major structural problems
* 75 per cent could easily get to places needed, similar to in 2008 (table 11A.5.1).

Refer to sections 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*, 5.3 *Engagement of services* and chapter 8 *Healthy lives* for further information on factors connected to vitality.

### Future directions in data

The Mayi Kuwayu Study is a relatively new longitudinal data set that explores how the health and wellbeing of Aboriginal and Torres Strait Islander people is linked to connection to Country, cultural practices, spirituality and language use. Research using this data set is not yet available, but may quantify the associations and pathways between cultural practice and expression, social determinants of health, health behaviours, and health and wellbeing outcomes for Aboriginal and Torres Strait Islander people.

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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 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, and drinking no more than four standard drinks on a single occasion reduces the risk arising from that occasion. [↑](#footnote-ref-2)
3. The National Indigenous Reform Agreement was in effect at the time of drafting this report. [↑](#footnote-ref-3)
4. 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 from 2010-11 to 2018-19, as well as data for the six jurisdictions from 2004-05 to 2018-19. [↑](#footnote-ref-4)
5. Report not consuming alcohol in the previous 12 months or having never consumed alcohol. [↑](#footnote-ref-5)
6. Alcohol Use Disorder is a diagnosis described in the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM‐5). [↑](#footnote-ref-6)
7. 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-7)
8. In this section, the terms ‘illicit substance use’ or ‘substance misuse’ refer to use of substances that are illegal to possess (such as heroin) and misuse of substances that are legally available (such as petrol, glue, paint and prescription drugs). Misuse of legal substances (volatile substance use) can result in sudden death, asphyxiation or neurological and cognitive effects. [↑](#footnote-ref-8)
9. Data on hospitalisations only cover illnesses and conditions directly attributable to drug use that result in admission to a hospital. They do not include conditions for which drug use may be a contributing factor but where the link is not direct and immediate. [↑](#footnote-ref-9)
10. For NSW, Queensland, WA, SA and the NT only (as these jurisdictions have sufficient levels of Aboriginal and Torres Strait Islander identification and numbers of deaths to support analysis). [↑](#footnote-ref-10)
11. Leske et al (2016) and Snijder et al (2020) both conducted international systematic reviews which included Australia. [↑](#footnote-ref-11)
12. 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-12)
13. 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-13)
14. The method of proceeding is the type of legal action (court or non-court) initiated by police against a person as a result of an investigation of an offence. [↑](#footnote-ref-14)
15. Sentenced supervision refers to both detention and community-based supervision. This is referenced here rather than the subset of detention as almost all first sentences are community-based, for both Aboriginal and Torres Strait Islander and non-Indigenous youth (AIHW 2019). [↑](#footnote-ref-15)
16. 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-16)