# 11 Safe and supportive communities

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| Strategic areas for action |
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| Governance and 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 (sometimes referred to as positive ‘social capital’). 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. Reducing drug related harm can improve health, social and economic outcomes at both individual and community levels
* juvenile diversions (section 11.3) — Aboriginal and Torres Strait Islander young people have a high rate of contact with the juvenile justice system (section 4.12). Police cautioning and conferencing processes can reduce the negative labelling and stigmatisation associated with formal contact with the criminal justice system, and the negative effects of contact with other offenders through the criminal justice system
* repeat offending (section 11.4) — Aboriginal and Torres Strait Islander Australians are over‑represented in prisons (section 4.12). 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. Reducing re‑incarceration may also help break the intergenerational offending cycle (whereby incarceration of one generation affects later generations through the breakdown of family structures)
* 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 4.10)
* family and community violence (section 4.11)
* imprisonment and juvenile detention (section 4.12).

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

* governance, leadership and culture (valuing Indigenous Australians and their culture, participation in decision making, engagement with services) (chapter 5)
* early child development (maternal health, teenage birth rate, early childhood hospitalisations, basic skills for life and learning) (chapter 6)
* education and training (school attendance and engagement) (chapter 7)
* healthy lives (mental health, suicide and self‑harm) (chapter 8)
* economic participation (employment status, Indigenous owned and controlled land and business, home ownership, income support) (chapter 9)
* home environment (overcrowding, access to water, sewerage and electricity) (chapter 10).

#### Attachment tables

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 Review web page (www.pc.gov.au/gsp), or users can contact the Secretariat directly.

## 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, and a significant contributor to violence in Aboriginal and Torres Strait Islander communities.
* Based on self‑report by Aboriginal and Torres Strait Islander adults in 2012‑13:
* 22.7 per cent reported not consuming alcohol in the previous 12 months (after adjusting for differences in population age structures, this was 1.6 times the rate for non‑Indigenous adults)
* 19.7 per cent reported exceeding lifetime alcohol risk guidelines, similar to 2004‑05 (after adjusting for differences in population age structures, this was similar to the proportion for non‑Indigenous adults in 2011-12)
* 57.0 per cent reported exceeding single occasion risk guidelines in the previous 12 months (after adjusting for differences in population age structures, this was 1.1 times the rate for non-Indigenous adults)
* the age adjusted rate for Aboriginal and Torres Strait Islander adults exceeding the guidelines at least once a week was lower than the rate for non-Indigenous adults (ratio of 0.6:1)
* the age adjusted rate for Aboriginal and Torres Strait Islander adults exceeding the guidelines less often than once a week was higher than the rate for non-Indigenous adults (ratio of 2.5:1) (tables 11A.1.1, 11A.1.5, 11A.1.12 and figure 11.1.1).
* Between 2004‑05 and 2012‑13, 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 12.1 times the rate for other Australians (table 11A.1.23).
* From 2003–2007 to 2008–2012, 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 around 5 times the rate for non‑Indigenous Australians (tables 11A.1.26‑27).
* In 2011‑12, the proportion of Aboriginal and Torres Strait Islander homicides involving both the victim and offender having consumed alcohol at the time of the offence (78.9 per cent — 15 out of 19) was higher than the proportion of non‑Indigenous homicides (14.8 per cent — 17 out of 115) (table 11A.1.28).
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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 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 (based on the concept of ‘Lifetime risk of alcohol harm’ in the NHMRC 2009 guidelines).The most recent available data are from the ABS Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS) for 2012‑13 (all jurisdictions; remoteness; sex; age). Comparable non‑Indigenous data are sourced from the ABS Australian Health Survey (AHS) with data for 2011-12. Indicators using both AATSIHS (2012-13) and AHS (2011-12) are referenced as 2011–13.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; Rehm, Klotsche and Patra 2007). 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 (Calabria et al. 2010). See section 4.8 for further information on disability and chronic disease, and section 8.8 for further information on suicide and self‑harm.

Alcohol‑related harm to health is not limited to drinkers but also affects families, bystanders and the broader community (NHMRC 2009). Excessive alcohol consumption contributes to workplace problems, child abuse and neglect, financial problems (poverty), family breakdown, interpersonal/domestic violence, and crime (Laslett et al. 2010; Wild and Anderson 2007). Alcohol is a significant contributor to violence in Aboriginal and Torres Strait Islander communities (HEREOC 2006; Livingston 2011; Meulerners et al. 2010; Wundersitz 2010). Substantiated child abuse and neglect is covered under headline indicator 4.10. Family and community violence is covered under headline indicator 4.11.

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). Section 6.2 includes information on alcohol consumption during pregnancy.

### Levels of risky alcohol consumption

In 2009, the NHMRC released new Australian *Alcohol Guidelines to Reduce Health Risks from Drinking Alcohol* (NHMRC 2009). The latest data on levels of risky alcohol consumption are from the ABS Australian Aboriginal and Torres Strait Islander Health Survey for 2012‑13 and are based on these guidelines. Historical 2004‑05 data are reported according to the 2009 guidelines to provide a comparable time series.

In 2012‑13, 22.7 per cent of Aboriginal and Torres Strait Islander adults reported not consuming any alcohol in the previous 12 months (after adjusting for differences in population age structures, this was 1.6 times the rate for non-Indigenous adults) (table 11A.1.5).

#### 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. These lifetime risk guidelines are the basis of the NIRA indicator on *levels of risky alcohol consumption* (see box 11.1.2).

In 2012‑13, 19.7 per cent of Aboriginal and Torres Strait Islander adults reported exceeding lifetime risk guidelines — not significantly different to the proportion in 2004‑05 — with a lower proportion in very remote areas (15.6 per cent) (tables 11A.1.1‑2 and 11A.1.12).

After adjusting for differences in population age structures, Aboriginal and Torres Strait Islander and non‑Indigenous adults reported exceeding the lifetime risk guidelines at much the same rate in 2011–13 (table 11A.1.5). The proportions of Aboriginal and Torres Strait Islander and non‑Indigenous adults reported exceeding the lifetime risk guidelines at similar rates in 2004‑05 (table 11A.1.16).

The proportion of Aboriginal and Torres Strait Islander adults that reported exceeding lifetime risk guidelines was lower in very remote areas compared with other areas (specifically inner regional and remote areas), whilst for non‑Indigenous Australians the proportion was higher in remote areas compared with major cities (table 11A.1.8).

#### 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.

In 2012‑13, 57.0 per cent of Aboriginal and Torres Strait Islander adults reported exceeding the single occasion risk guidelines on at least one occasion in the previous 12 months, with a lower proportion in very remote areas (45.3 per cent) (tables 11A.1.1-2).

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| Figure 11.1.1 Exceeding single occasion risk guidelines in the previous 12 months, people aged 18 years and over, 2011–13**a,b,c,d** |
| Figure 11.1.1 Exceeding single occasion risk guidelines in the previous 12 months, people aged 18 years and over, 2011-13  More details can be found within the text surrounding this image. |
| a Based on responses to questions about frequency of consumption of specified number of drinks in the previous 12 months. ‘In the previous 12 months’ is defined as persons who exceeded single occasion risk guidelines on at least one occasion in the previous 12 months. The number of drinks was based on the NHMRC guidelines for exceeding single occasion risk guidelines for alcohol consumption for males and females. b Data are age standardised. c Relative standard errors and 95 per cent confidence intervals should be considered when interpreting these data, and are available in table 11A.1.5. d The 2011–13 reference year includes data for Aboriginal and Torres Strait Islander Australians from the 2012‑13 AATSIHS. Data for non‑Indigenous Australians are from the 2011–13 AHS (for the period 2011‑12). e Persons who exceeded single occasion risk guidelines at least once a week in the previous 12 months. f  Persons who exceeded single occasion risk guidelines less than once a week in the previous 12 months. |
| *Sources*: ABS (unpublished) Australian Aboriginal and Torres Strait Islander Health Survey 2012‑13 (NATSIHS component) and ABS (unpublished) Australian Health Survey 2011–13 (NHS component for 2011-12); table 11A.1.5. |
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In 2011–13, after adjusting for differences in population age structures, the proportion of Aboriginal and Torres Strait Islander adults exceeding the single occasion risk guidelines at least once a week was lower than for non‑Indigenous adults (ratio of 0.6:1). However, a greater proportion of Aboriginal and Torres Strait Islander adults exceeded the guidelines at least once in the previous 12 months (ratio of 2.5:1) (figure 11A.1.1).

The proportion of Aboriginal and Torres Strait Islander adults exceeding single occasion risk was lower in very remote areas compared to other areas, whilst for non‑Indigenous adults the proportion was lower in major cities compared to other areas (table 11A.1.8).

The COAG Reform Council (CRC 2014) analysed 2011–13 AATSIHS/AHS data using NHMRC 2001 guidelines on the number of standard drinks in a single session. This analysis showed that, after adjusting for differences in population age structures, among people aged 15 years and over, who drank at least once in the previous 12 months, a higher proportion of Aboriginal and Torres Strait Islander Australians drank higher volumes in a single occasion than non‑Indigenous Australians:

* Aboriginal and Torres Strait Islander males reported drinking 11 or more standard drinks (2001 high-risk threshold for males) on a single occasion at 1.3 times the rate of non‑Indigenous males
* Aboriginal and Torres Strait Islander females reported drinking 7 or more drinks on a single occasion (2001 high-risk threshold for females) at 1.5 times the rate of non‑Indigenous females.

Alcohol risk level data by State and Territory are available in tables 11A.1.1–21.

### 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 resulting in admission to a hospital and 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).

From 2010-11, Indigenous status in hospital separations data are considered of sufficient quality for reporting in all jurisdictions. 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 hospitalisations data. The attachment tables for this report include data for all jurisdictions for 2010‑11 to 2012‑13, as well as data for the six jurisdictions for 2004‑05 to 2012‑13.

In 2012‑13, after adjusting for differences in population age structures, the most common type of alcohol related hospitalisation for Aboriginal and Torres Strait Islander Australians was for acute intoxication around 12 times the rate for non‑Indigenous Australians (table 11A.1.22). The hospitalisation rate for acute intoxication for Aboriginal and Torres Strait Islander Australians in remote and very remote areas was double the rate in major cities (table 11A.1.24).

Between 2004-05 and 2012-13, 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 12.1 times the rate for other Australians (table 11A.1.23).

Hospitalisations related to alcohol use data by State and Territory are available in table 11A.1.25.

### 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.

From 2003–2007 to 2008–2012, 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 around 5 times the rate for non-Indigenous Australians (tables 11A.1.26‑27).

Data on alcohol induced deaths are also available by sex and State and Territory in tables 11A.1.26-27.

### Alcohol involvement in homicides

The relationship between excessive alcohol consumption, violence, crime and injury is well documented (see section 4.11; Bryant and Willis 2008; Bryant 2009; HEREOC 2006; Livingston 2011; Meulerners et al. 2010; Snowball and Weatherburn 2006; Wundersitz 2010). The latest data on alcohol related homicides are for 2011‑12, from the Australian Institute of Criminology National Homicide Monitoring Program.

Of the 264 recorded homicides in 2011‑12 (table 4A.11.35), 144 homicides have known Indigenous status of offender and victim, 19 involved Aboriginal and Torres Strait Islander Australians as both victims and offenders (table 4A.11.37). Of these 19 Aboriginal and Torres Strait Islander homicides, 15 (78.9 per cent) involved both the victim and offender having consumed alcohol at the time of the offence. In comparison, of the 115 homicides involving only non‑Indigenous victims and offenders, less than half (38, or 33.0 per cent) had any alcohol involvement (table 11A.1.28).

The number of Aboriginal and Torres Strait Islander homicides fluctuated over the period 1999–2000 to 2011‑12. However, the majority of Aboriginal and Torres Strait Islander homicides each year involved alcohol consumption (table 11A.1.28).

### Things that work

There is some evidence that supply reduction, demand reduction and harm minimisation may be effective in reducing the impact of excessive alcohol consumption (Gray and Wilkes 2010). However, evaluations carried out on alcohol management plans (AMPs) in Katherine, Tennant Creek and Alice Springs cite difficulties in attributing the changes in consumption, assaults, crime and admissions to sobering shelters solely to the introduction of AMPs (d’Abbs et al. 2010 and Senior et al. 2009 cited in Smith et al. (2013). Hudson (2011) states that, to be effective, alcohol restrictions should go hand in hand with initiatives that address underlying causes, such as lack of education and employment. Similarly, Smith et al. (2013) noted that, when AMPs are implemented, they often narrowly cover supply issues and do not address harm and demand reduction measures (for example, health promotion, treatment and ongoing care), even where these were included in the original design.

The most effective AMPs are those negotiated at a local community level (Smith et al. 2013). Box 11.1.3 provides an example of an effective community‑led alcohol restriction measure.

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| Box 11.1.3 Things that work — alcohol consumption and harm |
| The **Fitzroy Crossing Liquor Restriction** (WA) was the result of community action. Following representations from local women, in 2007 the WA Director of Liquor Licensing imposed restrictions on liquor outlets in the state’s Kimberley region. The restrictions allowed only drinks with less than 2.7 per cent alcohol content to be sold for take‑away consumption (Oscar and Pedersen 2011). An independent evaluation by the University of Notre Dame (at 12 and 24 months after implementation of the alcohol restrictions) involving interviews with 184 people from Fitzroy Crossing and local communities, and a quantitative analysis of police data for the local area, concluded that positive effects on domestic violence, public violence and antisocial behaviour (and an increase in families purchasing more food and clothes) had resulted from introducing a program that restricted the supply of alcohol into the community (Kinnane et al. 2009, 2010).The benefits appeared to reach a high point at the 12 month mark of the liquor restrictions, with a gradual erosion of benefits over the following 12 months (although the overall impact of the restriction remained positive). Many respondents considered that the reduced benefits were due in part to the missed opportunity of the State to follow up on promised programs and support, and due to a fire that destroyed the local shopping centre.Initially imposed for a six‑month period, the restrictions have now been extended indefinitely, with an annual review to test ongoing effectiveness (Kinnane et al. 2010). In May 2009, similar restrictions on the sale of take‑away alcohol were imposed in the neighbouring town of Halls Creek, followed by other remote Kimberley communities. |
| *Sources*: Oscar, J. and Pedersen, H. 2011, ‘*Alcohol Restrictions in the Fitzroy Valley: Trauma and Resilience*’, in Brigg, M. and Maddison, S. (eds), *Unsettling the Settler State: Creativity and Resistance in Indigenous Settler-State Governance*, The Federation Press, NSW; Kinnane, S., Farringdon, F., Henderson-Yates, L. and Parker, H. 2009, *Fitzroy Valley Alcohol Restriction Report: An evaluation of the effects of alcohol restrictions in Fitzroy Crossing relating to measurable health and social outcomes, community perceptions and alcohol related behaviours after a 12 month period*, Drug and Alcohol Office, Western Australia, The University of Notre Dame Australia; Kinnane et al. 2010, *Fitzroy Valley Alcohol Restriction Report: An evaluation of the effects of alcohol restrictions in Fitzroy Crossing relating to measurable health and social outcomes, community perceptions and alcohol related behaviours after two years*, Drug and Alcohol Office, Western Australia; The University of Notre Dame Australia. Also cited in Day, Francisco and Jones 2013, *Programs to improve interpersonal safety in Indigenous communities: evidence and issues*, Issues paper no. 4 produced for the Closing the Gap Clearinghouse, 2013; Gray, W. and Wilkes, E. 2011, *Alcohol restrictions in Indigenous communities: an effective strategy if Indigenous-led*, Medical Journal of Australia, https://www.mja.com.au/journal/2011/194/10/alcohol-restrictions-indigenous-communities-effective-strategy-if-indigenous-led (accessed 1 July 2014). |
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### Future directions in data

The AATSIHS and AHS collected a range of other health‑related information that can be analysed in conjunction with alcohol risk level. Aggregate levels of alcohol consumption for the total population implied by the AHS are somewhat less than the estimates of consumption of alcohol based on taxation and customs data (ABS 2013). This suggests a tendency towards underreporting of alcohol consumption in self‑report surveys.

The three yearly AIHW National Drug Strategy Household Survey (most recently conducted in 2013, with full results anticipated for release in November 2014) has a small Aboriginal and Torres Strait Islander sample (461 respondents in the 2013 survey), and is not designed to make robust comparisons between Aboriginal and Torres Strait Islander Australians and non‑Indigenous Australians. The AIHW is working on improving Aboriginal and Torres Strait Islander coverage in this survey.

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## 11.2 Drug and other substance use and harm[[2]](#footnote-2)

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| Box 11.2.1 Key messages |
| * In 2012-13, around half (47.3 per cent) of Aboriginal and Torres Strait Islander adults in non‑remote areas reported never having used substances. This was similar to the proportion in surveys in 2004-05 and 2008 (table 11A.2.1).
* The proportion of Aboriginal and Torres Strait Islander adults in non-remote areas reporting illicit substance use in the 12 months prior to interview was similar between 2002 and 2012‑13. However, the proportion increased (although not statistically significantly) from 25.5 per cent in 2002 to 28.0 per cent in 2004-05, before falling to 23.4 per cent in 2012-13, driven by a decrease in reported use by females (from 24.4 per cent in 2004‑05 to 19.4 per cent in 2012‑13) (table 11A.2.1 and figure 11.2.1).
* Between 2004‑05 and 2012‑13, after adjusting for differences in population age structures, for NSW, Victoria, Queensland, WA, SA and the NT combined:
* rates of hospitalisation for poisoning for Aboriginal and Torres Strait Islander Australians increased from 1.3 to 2.3 times the rate for other Australians
* rates of hospitalisation for mental/behavioural disorders for Aboriginal and Torres Strait Islander Australians increased from 2.5 to 3.0 times the rate for other Australians (table 11A.2.5).
* From 2003–2007 to 2008–2012, 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 consistently around 1.5 times the rate for non‑Indigenous Australians (tables 11A.2.8‑9).
* In 2011‑12, a smaller proportion of Aboriginal and Torres Strait Islander homicides had drug involvement (3 out of 19) than non‑Indigenous homicides (33 out of 115) (table 11A.2.10).
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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 2012‑13 (all jurisdictions; sex; age). Data are not available for non‑Indigenous Australians or (for the 2004‑05 survey) remote areas. To maintain a comparable time series, the majority of survey data presented in this section relate to non-remote areas only. |
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| Box 11.2.2 (continued) |
| 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’). However, use of illicit drugs also has significant effects. The use of illicit drugs contributes to illness and disease, accidents and injury, violence and crime, family and social disruption, and workplace problems (Catto and Thomson 2008).

Illicit substance use can be divided into two categories: use of substances which are illegal to possess (such as heroin) and misuse of substances which are legally available (such as petrol sniffing or misuse of prescription drugs). Use of the term ‘illicit substance use’ in this section also refers to the misuse of legal substances.

### Substance use

Data on the use of illicit drugs are derived from surveys. The sensitive and personal nature of these questions may affect respondents’ willingness to respond (acceptance of the substance use form), and the nature of the responses.

Nationally in 2012-13, reported substance use[[3]](#footnote-3) for Aboriginal and Torres Strait Islander Australians aged 15 years and over was lower in remote areas (18.8 per cent) than in non‑remote areas (23.3 per cent) (ABS 2014).

The rest of this section reports data on non-remote areas for Aboriginal and Torres Strait Islander Australians (aged 18 years and over), to enable time series comparison across all four survey periods.

In 2012‑13, for Aboriginal and Torres Strait Islander adults in non–remote areas:

* around half (47.3 per cent) reported never having used substances. This was similar to the proportion in surveys in 2004‑05 and 2008 (table 11A.2.1)
* a greater proportion in the 55 years and over age group (75.4 per cent) reported never having used substances than those in other age groups (between 37.9 per cent and 46.9 per cent) (table 11A.2.3)
* a greater proportion of females (53.4 per cent) than males (40.6 per cent) reported never having used substances (figure 11.2.1).

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| Figure 11.2.1 Substance use for Indigenous people aged 18 years and over (non‑remote areas), by sex, 2002 to 2012‑13**a**  |
| Figure 11.2.1 Substance use for Indigenous people aged 18 years and over non remote areas, by sex, 2002 to 2012-13  More details can be found within the text surrounding this image. |
| 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; ABS (unpublished) National Aboriginal and Torres Strait Islander Health Survey 2004‑05; ABS (unpublished) National Aboriginal and Torres Strait Islander Social Survey 2008; ABS (unpublished) Australian Aboriginal and Torres Strait Islander Health Survey 2012‑13 (NATSIHS component); table 11A.2.2. |
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The proportion of Aboriginal and Torres Strait Islander adults reporting illicit substance use in the 12 months prior to interview was similar between 2002 and 2012‑13. However, increased (although not statistically significantly) from 25.5 per cent in 2002 to 28.0 per cent in 2004-05, before falling to 23.4 per cent in 2012-13 (table 11A.2.1), driven by a decrease in reported use by females (from 24.4 per cent in 2004 ‑05 to 19.4 per cent in 2012‑13) (figure 11.2.1).

In surveys in 2002, 2004‑05, 2008 and 2012‑13, for adults in non-remote areas:

* higher proportions of males than females reported using substances in the 12 months prior to interview (27.7 per cent of males compared with 19.4 per cent of females in 2012‑13) (figure 11.2.1).
* ‘marijuana, hashish or cannabis resin’ were the most commonly used drugs for both males (24.2 per cent in 2012-13) and females (14.7 per cent in 2012‑13) (table 11A.2.2).

Illicit substance use for different age groups has changed over time:

* the proportion of 25–34 year olds using illicit substances in the 12 months prior to interview decreased from 37.7 per cent in 2004‑05 to 28.3 per cent in 2012‑13
* the proportion of 45–54 year olds who had used illicit substances but not in the 12 months prior to interview increased from 15.5 per cent in 2002 to 31.8 per cent in 2012‑13, with a corresponding decrease in the proportion of 45–54 year olds who had never used illicit substances (from 71.4 per cent to 43.6 per cent) (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.

From 2010-11, Indigenous status in hospital separations data are considered of sufficient quality for reporting in all jurisdictions. Prior to 2010-11, six jurisdictions (NSW, Victoria, Queensland, WA, SA and the NT) were considered to have acceptable quality of Indigenous identification in hospitalisation data. The attachment tables for this report include data for all jurisdictions for 2010-11 to 2012-13, as well as data for the six jurisdictions for 2004-05 to 2012-13.

In 2012-13, after adjusting for differences in population age structures:

* the most common drug-related conditions resulting in hospitalisations of both Aboriginal and Torres Strait Islander and non-Indigenous Australians were ‘poisoning’ and ‘mental and behavioural disorders’ (table 11A.2.4)
* the hospitalisation rate for Aboriginal and Torres Strait Islander Australians for mental and behavioural disorders caused by drug use was around three times the rate for non-Indigenous Australians (table 11A.2.4)
* the hospitalisation rate for Aboriginal and Torres Strait Islander Australians for poisoning was more than twice the rate for non-Indigenous Australians (table 11A.2.4)
* the hospitalisation rate for drug related conditions for Aboriginal and Torres Strait Islander Australians decreased with remoteness (except for accidental poisoning)
(table 11A.2.6).

Between 2004‑05 and 2012‑13, after adjusting for differences in population age structures, for NSW, Victoria, Queensland, WA, SA and the NT combined:

* rates of hospitalisation for poisoning for Aboriginal and Torres Strait Islander Australians increased from 1.3 to 2.3 times the rate for other Australians
* rates of hospitalisation for mental and behavioural disorders for Aboriginal and Torres Strait Islander Australians increased from 2.5 to 3.0 times the rate for other Australians (table 11A.2.5).

Hospitalisations related to drug use data by State and Territory are available in table 11A.2.7.

### 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.

From 2003–2007 to 2008–2012, 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 consistently around 1.5 times the rate for non‑Indigenous Australians (tables 11A.2.8‑9).

### Drug involvement in homicides

Of the 264 recorded homicides in 2011‑12 (table 4A.11.35), 144 homicides have known Indigenous status of offender and victim (table 4A.11.37):

* 19 homicides involved Aboriginal and Torres Strait Islander Australians as both victims and offenders (table 4A.11.37). In three of these homicides, the victim was under the influence of drugs. There were no cases in which the offender was under the influence of drugs
* 115 homicides involved only non‑Indigenous victims and offenders. Of these homicides, 33 (28.7 per cent) had drug involvement — 15 (13.0 per cent) involved the victim under the influence of drugs, 10 (8.7 per cent) involved the offender under the influence of drugs and eight (7.0 per cent) involved both the offender and victim under the influence of drugs
* 10 homicides involved Aboriginal and Torres Strait Islander Australians as either the victim or the offender. Of these homicides, two had drug involvement — in one homicide both victim and offender were under the influence of drugs, and in the other only the offender was under the influence of drugs (table 11A.2.10).

The number of Aboriginal and Torres Strait Islander homicides and the influence of drugs on the victim and/or offender fluctuated with no clear trend over the period 1999–2000 to 2011‑12 (table 11A.2.10).

### Things that work

The misuse of substances such as inhalants (for example, petrol, glue, paint and butane gas) can lead to serious health consequences, including long term brain damage, disability or even death. It can also cause the social alienation of users and contribute to violence and crime (Access Economics 2006; Community Affairs References Committee 2006). Box 11.2.3 provides an example of how petrol sniffing is being addressed in central Australian communities.

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| Box 11.2.3 Things that work — drug and other substance use and harm |
| The Steering Committee considers that, although the program below has not been recently evaluated, the introduction of Opal fuels, together with access to support services, appears to have been a successful program to address petrol sniffing. A follow‑up evaluation to assess the long term impact of the program would be valuable. **OPAL fuel** (a low aromatic fuel) was introduced in the NT and WA in 2006, to reduce the harmful, risky health behaviour of petrol sniffing, and to prevent associated antisocial behaviour, offending and contact with the criminal justice system. OPAL fuel, when sniffed does not produce the ‘high’ that is produced by traditional petrol. An independent evaluation by d’ Abbs and Shaw (2008) found that the prevalence of sniffing had declined in 17 out of 20 sample communities in which OPAL fuel had been introduced (and an increase in communities with no petrol sniffing from two to nine). There had been a decrease of 431 (70 per cent) in the number of people sniffing between baseline (2005–2006) and follow up (March‑May 2008). The evaluation concluded that, although decreased petrol sniffing could not be attributed solely to the introduction of OPAL fuel, many community residents believed that it had made a significant contribution. The evaluators 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. 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

Alcohol and other drug use is believed to be higher among Aboriginal and Torres Strait Islander Australians than among non-Indigenous Australians for many drugs. However, available data sources are subject to a range of limitations and should be used with caution. An accurate account of prevalence levels is not possible with current datasets (NIDAC unpublished).

The National Drug Strategy 2010–2015 committed to the development of a National Aboriginal and Torres Strait Islander Peoples Drug Strategy (the Strategy), in recognition of the unique needs of Aboriginal and Torres Strait Islander people. The Strategy (currently being finalised) will set a national direction for reducing harm among Aboriginal and Torres Strait Islander peoples (Australian Government unpublished).

The three yearly AIHW National Drug Strategy Household Survey (most recently conducted in 2013, with full results anticipated for release in November 2014) has a small Aboriginal and Torres Strait Islander sample (461 respondents in the 2013 survey), and is not designed to make robust comparisons between Aboriginal and Torres Strait Islander Australians and non‑Indigenous Australians. The AIHW is working on improving Aboriginal and Torres Strait Islander coverage in this survey.

### References

D’ Abbs, P. and Shaw, G. 2008, *Executive Summary of the ‘Evaluation of the Impact of Opal Fuel’*, Commonwealth Department of Health and Ageing.

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## 11.3 Juvenile diversions[[4]](#footnote-4)

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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, by reducing negative labelling and stigmatisation, and the negative effects of contact with other offenders.
* Rates of diversion from formal criminal justice processes for Aboriginal and Torres Strait Islander young people aged 10–17 years are around one‑half to two‑thirds those for non‑Indigenous young people, and have remained relatively unchanged over recent years (figures 11.3.1 to 11.3.6, table 11A.3.32).
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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 2012 (or the 2012‑13 financial 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 4.10 includes information on child protection and section 4.11 includes information on family and community violence. Section 4.12 includes information on imprisonment and juvenile detention.

Police cautioning and conferencing processes are swift and economically efficient responses to offending. They can also reduce the negative labelling and stigmatisation associated with formal contact with the criminal justice system, and the criminogenic effects of contact with other offenders through 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, with approaches varying from informal police cautioning to legislated youth conferencing. Differences in programs and data collection mean that data are not comparable across jurisdictions.

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).

### New South Wales

Youth diversions in NSW are legislated under the *Young Offenders Act 1997 (NSW)* and administered by the NSW Department of Juvenile Justice. Under the Act, young offenders can be diverted using warnings, police cautions and youth justice conferences. Warnings apply for the least serious offences, while more serious offences may elicit cautions, conferences and finally court for the most serious offences. Infringement notices consisting of an on‑the‑spot fine can be issued for certain offences.

NSW 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.

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| Figure 11.3.1 Proportion of alleged young offenders (aged 10–17 years) diverted, New South Wales, 2004 to 2012**a** |
| Figure 11.3.1 Proportion of alleged young offenders aged 10-17 years diverted, New South Wales, 2004 to 2012  More details can be found within the text surrounding this image. |
| a Data represents persons of interest (POIs) or alleged offenders who have come to the attention of NSW Police for a recorded criminal incident (driving offences are excluded). Some POIs are formally proceeded against to court and some are proceeded against other than to court whilst others are not proceeded against. The POIs included have all been proceeded against. POIs are not a count of unique offenders. Where an individual is involved in multiple criminal incidents throughout the year they will appear as a POI multiple times. |
| *Source*: NSW Bureau of Crime Statistic & Research (unpublished), table 11A.3.1. |
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In 2012, 34.2 per cent of Aboriginal and Torres Strait Islander alleged young offenders received a diversion by police. This rate has been relatively steady over time, ranging between 31 per cent and 36 per cent from 2004 to 2012 (figure 11.3.1). Over this period, Aboriginal and Torres Strait Islander alleged young offenders were diverted at around half the rate of non‑Indigenous alleged young offenders (70.2 per cent in 2012) (figure 11.3.1).

These rates may be affected by the type of alleged offence. For Aboriginal and Torres Strait Islander alleged young offenders, the most common type of offence was ‘theft’ (30.4 per cent), with around two in five diverted (compared with around three in five non‑Indigenous alleged young offenders diverted for this offence type). For non‑Indigenous alleged offenders, the most common type of offence was ‘transport regulatory offences’ (36.1 per cent) (table 11A.3.3). Data on diversions by sex and offence type are available in table 11A.3.2.

### Victoria

In Victoria, data on youth apprehensions describe offences charged by police as either an ‘arrest’ or ‘summons’, while a diversion is described as a ‘caution’. Victoria is the only state where the cautioning of offenders is not legislated — it is left to the discretion of police officers. Indigenous status is derived from the racial appearance of the offender, which is a subjective assessment by the police officer.

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| Figure 11.3.2 Proportion of alleged young offenders (aged 10–17 years) cautioned when processed by police, Victoria, 2004‑05 to 2012‑13**a,b** |
| Figure 11.3.2 Proportion of alleged young offenders aged 10-17 years cautioned when processed by police, Victoria, 2004-05 to 2012-13  More details can be found within the text surrounding this image. |
| a Indigenous status is derived from the racial appearance of the offender which is a subjective assessment of the police officer. b Percentages are based on the proportion of young offenders cautioned when first processed by police in a financial year. |
| *Source*: Victoria Police (unpublished); table 11A.3.6. |
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In 2012‑13, 8.6 per cent of Aboriginal and Torres Strait Islander alleged young offenders were formally cautioned, around half the rate of non‑Indigenous alleged young offenders (18.3 per cent) (figure 11.3.2). The diversion rate for Aboriginal and Torres Strait Islander alleged young offenders has fluctuated over time, ranging between 8.6 per cent and 14.7 per cent from 2004‑05 to 2012‑13 (figure 11.3.2). The diversion rate for non‑Indigenous alleged young offenders has declined from a high of 30.9 per cent in 2006‑07 to 18.3 per cent in 2012‑13 (figure 11.3.2).

In 2012-13, the most common type of offence for both Aboriginal and Torres Strait Islander alleged young offenders and non‑Indigenous alleged young offenders was ‘crime against property’ (around 60 per cent) followed by ‘crime against the person’ (around 20 per cent) (table 11A.3.8). Historical data on diversions by type of offence are available in tables 11A.3.9–16. Data on by sex and offence type are available in table 11A.3.7.

### Queensland

In Queensland, police data include the diversionary methods of ‘caution’ and ‘community conference’ as alternatives to ‘arrest’, ‘notice to appear’, ‘summons’ or ‘warrant’. Offender statistics are based on offence counts and should be interpreted with caution.

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| Figure 11.3.3 Proportion of alleged young offenders (aged 10–16 years) diverted, Queensland, 2006‑07 to 2012‑13**a,b** |
| Figure 11.3.3 Proportion of alleged young offenders aged 10-16 years diverted, Queensland, 2006-07 to 2012-13   More details can be found within the text surrounding this image. |
| a Only those offenders whose age, sex and Indigenous status were identified are included. b Indigenous status is based on self‑identification by the young offender. |
| *Source*: Queensland Police Service (various years), *Annual Statistical Review 2011‑12* (and various years); tables 11A.3.17 to 11A.3.23. |
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In 2012‑13, 24.0 per cent of Aboriginal and Torres Strait Islander alleged young offenders were cautioned or had a community conference, compared with 42.5 per cent of non‑Indigenous alleged young offenders (figure 11.3.3). The diversion rate for Aboriginal and Torres Strait Islander alleged young offenders has fluctuated over time, ranging between 24.0 per cent and 32.0 per cent from 2006‑07 to 2012‑13 (figure 11.3.3). The diversion rate for non‑Indigenous alleged young offenders has decreased from 57.6 per cent in 2006‑07 to 42.5 per cent in 2012‑13 (figure 11.3.3).

In 2012‑13, for all alleged young offenders, the most common types of offences were offences against property including ‘unlawful entry’ and ‘theft’ (72.1 per cent for Aboriginal and Torres Strait Islander, and 58.2 per cent for non‑Indigenous, alleged young offenders) (table 11A.3.17). Historical data on diversions by type of offence are available in tables 11A.3.18–23.

### Western Australia

Youth diversions are legislated under the *Young Offenders Act 1994 (WA)*. Under the Act, police officers can issue young offenders with a formal written caution, or the matter can be transferred to a Juvenile Justice Team (JJT) via police or court referral. Where the matter is referred to a JJT, young people are held accountable for their offending behaviour through meetings with their families, victims and police. No criminal conviction is recorded against the young person.

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| Figure 11.3.4 Proportion of alleged young offenders (aged 10–17 years) diverted, Western Australia, 2008‑09 to 2012‑13**a,b** |
| Figure 11.3.4 Proportion of alleged young offenders aged 10-17 years diverted, Western Australia, 2008-09 to 2012-13  More details can be found within the text surrounding this image. |
| a WA youth diversions include formal cautions and referrals to Juvenile Justice Teams as a proportion of the total recorded number of young people diverted or arrested. b Percentages are based on the proportion of young offenders cautioned when first processed by police in a financial year. |
| *Source*: WA Police (unpublished) FrontLine Incident Management System; table 11A.3.24. |
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In 2012‑13, 35.1 per cent of Aboriginal and Torres Strait Islander alleged young offenders were diverted through caution or transferred to a JJT, compared with 58.2 per cent of non‑Indigenous alleged young offenders (figure 11.3.4). The diversion rate for Aboriginal and Torres Strait Islander alleged young offenders increased from 29.5 per cent in 2008‑09 to 40.5 per cent in 2011‑12, while the diversion rate for non‑Indigenous alleged young offenders has been relatively steady at around 60 per cent (figure 11.3.4). Diversions to a JJT decreased in 2012-13, to 2008-09 levels (table 11A.3.24).

### South Australia

The South Australian *Young Offenders Act 1993 (SA)* legislates for a three tiered system of diversion, involving informal cautions, formal cautions and family conferences.

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| Figure 11.3.5 Proportion of alleged young offenders diverted (aged 10–17 years), South Australia, 2004 to 2012**a,b,c,d** |
| Figure 11.3.5 Proportion of alleged young offenders diverted aged 10-17 years, South Australia, 2004 to 2012  More details can be found within the text surrounding this image. |
| a Prior to 1 July 2007 the recording of the racial identity of the alleged offender largely reflected the apprehending officer’s opinion based on the physical appearance of the individual. From 1 July 2007, SA Police adopted the standard ABS question on Indigenous status for alleged offenders. b Youth diversions include both formal cautions and transfers to a family conference. c There are some counting rule differences between Office of Crime Statistics and Research and SA Police data on youth diversions. Moreover, SA Police’s recently refreshed data would show slightly higher proportions of diversions each year, as offences occurring in one reporting period may not receive a family conference until the next reporting period. d Numbers of youth apprehensions exclude those offences with an unknown method of processing. |
| *Sources*: Office of Crime Statistics and Research (OCSAR) 2005, *Crime and Justice in SA–Juvenile Justice 2004*, Attorney‑General’s Department, South Australia; OCSAR 2006, *Crime and Justice in SA–Juvenile Justice 2005*, Attorney‑General’s Department, South Australia; OCSAR 2010, *Crime and Justice in SA–Juvenile Justice 2007*, no. 44(2); OCSAR 2014 (unpublished), Attorney-General's Department, South Australia; table 11A.3.25. |
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In 2012, 30.5 per cent of Aboriginal and Torres Strait Islander alleged young offenders were diverted through formal caution or transfer to family conference, compared with 52.9 per cent for non‑Indigenous alleged young offenders. The difference between Aboriginal and Torres Strait Islander and non‑Indigenous youth diversions has remained similar since 2008 at around 20 percentage points (figure 11.3.5).

From 2004 to 2012, for both Aboriginal and Torres Strait Islander and non‑Indigenous young offenders, the most common types of offences were ‘larceny and receiving’ and ‘offences against good order’, accounting for over half of all offences (tables 11A.3.26 to 11A.3.30).

### Northern Territory

Northern Territory police data refer to apprehension cases rather than individual persons, and several cases can relate to the same offender.

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| Figure 11.3.6 Proportion of youth apprehensions diverted (aged10–17 years), Northern Territory, 2002 to 2013**a,b** |
| Figure 11.3.6 Proportion of youth apprehensions diverted aged 10-17 years, Northern Territory, 2002 to 2013   More details can be found within the text surrounding this image. |
| a Indigenous status is based on self‑identification by the young person. b Where cases did not result in a diversion, these cases either proceeded to court or were resolved in some other manner (it is not an indicator of the number of matters referred to the courts). |
| *Source*: NT Police (unpublished); table 11A.3.31. |
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In 2013, 28.3 per cent of Aboriginal and Torres Strait Islander alleged young offenders were diverted, compared with 40.4 per cent of non‑Indigenous alleged young offenders. The proportions of Aboriginal and Torres Strait Islander and non‑Indigenous youth diversions fluctuated between 2002 and 2013 with no discernible trend but with a gap in all years except 2007 (figure 11.3.6). Data on diversions by sex are available in table 11A.3.31.

### 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 2012‑13, 25.0 per cent of Aboriginal and Torres Strait Islander alleged young offenders were diverted, compared with 40.0 per cent of non‑Indigenous alleged young offenders (table 11A.3.32). Data on diversions by sex are available in table 11A.3.32.

### Things that work

Some programs that have successfully made diversionary alternatives more accessible for Aboriginal and Torres Strait Islander alleged young offenders are described in box 11.3.3.

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| Box 11.3.3 Things that work — juvenile diversions |
| Although not formally evaluated, the Steering Committee has identified the two programs below as promising practices worth further examination.**Ignite Basketball** (WA) aims to divert young people aged 12 to 17 years from the Armadale to Perth train lines and Northbridge on Saturday nights, as a way of reducing crime and antisocial behaviour. The program runs for 40 weeks of the year, hosting basketball games and, more recently, providing psychological support and counselling, including linking participants and families to referral agencies for ongoing support. Over 360 young people are registered in the program, with approximately 85 per cent identifying as Aboriginal and/or Torres Strait Islander.Since the inception of the program, the number of youth being detained in the Northbridge precinct has decreased: 102 in 2009, 45 in 2010, 27 in 2011, 481 in 2012, 27 in 2013 (WA Government unpublished).The **Regional Youth Justice Services** (WA) was introduced by the Department of Corrective Services in 2008. The program focuses on the prevention and diversion of young people from formal justice processes through the provision of advice and support, youth bail options, in‑court assistance and supervision of community based orders.The program was initially trialled in Kalgoorlie and Geraldton. The number of police cautions in Kalgoorlie increased by 41.4 per cent, and the number of police and judge referrals to a Juvenile Justice Service team in Geraldton increased by 82 per cent (DIA 2010). Regional Youth Justice Services have since been adopted in other regions and currently operate in the Goldfields, Mid‑West Gascoyne, West Kimberley, East Kimberley and the Pilbara regions (DOCS 2014) . |
| 1 The increase in the number of young people detained in 2012 may have been due to a lapse of a few months in program delivery (due to lack of funding). |
| *Sources*: DOCS (Department of Corrective Services, The Government of Western Australia) 2014, Regional Youth Justice Services, http://www.correctiveservices.wa.gov.au/youth-justice/regional-youth-justice.aspx (accessed 4 July 2014); DIA (Department of Indigenous Affairs, The Government of Western Australia) 2010, Closing the gap in Western Australia, http://www.dia.wa.gov.au/PageFiles/1442/COAG\_Newsletter\_December2010\_Edition3%20(2).pdf (accessed 4 July 2014). |
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### Future directions in data

Nationally comparable data on youth diversions by Indigenous status is a key data gap. Whilst data are collected on alleged offenders in the ABS Recorded Crime Offenders collection, the data quality for 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 they agreed to plead guilty to the alleged offence to be eligible for diversion.

### References

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## 11.4 Repeat offending[[5]](#footnote-5)

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| Box 11.4.1 Key messages |
| * Repeat offending and re‑incarceration are significant contributors to the over‑representation of Aboriginal and Torres Strait Islander Australians in the youth justice and criminal justice systems.
* Nationally on 30 June 2013, 77.0 per cent of Aboriginal and Torres Strait Islander prisoners and 50.9 per cent of non‑Indigenous prisoners had a known prior imprisonment. These proportions have remained relatively unchanged since 2000 (table 11A.4.1).
* A higher proportion of Aboriginal and Torres Strait Islander male prisoners (77.9 per cent) than Aboriginal and Torres Strait Islander female prisoners (67.8 per cent) had experienced prior adult imprisonment (figure 11.4.2).
* In 2011‑12, Aboriginal and Torres Strait Islander young people returned to youth justice supervision at between 1.3 and 1.5 times the rate of non‑Indigenous young people (AIHW 2013).
* In NSW, Queensland, SA, and the NT in 2012‑13, 40 to 47 per cent of Aboriginal and Torres Strait Islander offenders were proceeded against by police on more than one occasion, compared with 20 to 28 per cent of non‑Indigenous offenders (table 11A.4.3).
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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 (over three timeframes — within 1 year, 2 years, and during the entire time for which a young person is treated as a youth and therefore eligible to return).

The most recent available data for adult re‑imprisonment are from the ABS Prisoners in Australia collection for 30 June 2013 (all jurisdictions; sex). The most recent available data for returns to sentenced supervision are from the AIHW Juvenile Justice National Minimum Dataset (National). The AIHW data are available for the first time in this OID report. Some cohort studies measuring longitudinal outcomes of youth offending patterns have been published in previous OID reports. 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 and the NT; age; sex). |
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This section focuses on repeat offending. Imprisonment and juvenile detention are covered under section 4.12.

Repeat offending is defined as the reversion of an individual to criminal behaviour after he or she has been convicted of a prior offence. Repeat offending and re‑incarceration are significant contributors to the over‑representation of Aboriginal and Torres Strait Islander Australians in the youth justice and criminal justice systems (CTGCH 2013; Snowball and Weatherburn 2006). Weatherburn et al. (2009) found that a 10 per cent reduction in Aboriginal and Torres Strait Islander re-imprisonment would reduce the prison population by an estimated 365 prisoners, whilst the an equivalent reduction in the rate at which new Aboriginal and Torres Strait Islander sentenced prisoners arrive in custody would reduce the population by an estimated 166 prisoners.

Many factors contribute to the re‑offending behaviour of an individual.

Payne (2007) canvassed the literature on recidivism in Australia and found that certain characteristics are predictive of repeat offending, including:

* age of offender — criminal offending peaks in the mid to late teens, diminishing in adulthood
* criminal history — the younger the age of first offence, the greater the likelihood of higher levels of offending
* sex — for the majority of offences, females are less likely to reoffend
* Indigenous status — Aboriginal and Torres Strait Islander offenders are generally more likely to reoffend and to be reconvicted or reimprisoned upon release from prison.

Payne (2007) also found that situational factors potentially influencing the likelihood of repeat offending can include:

* unemployment (section 4.6)
* education and schooling — those with lower educational attainment (sections 4.5 and 4.7)
* residential location — those living in low socioeconomic areas or who are homeless (section 4.9 and chapter 10)
* family attachment — those with limited family attachment
* poor mental health (section 8.7)
* drug use (section 11.2).

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 (Richards 2011; Wartna 2009; Payne 2007). 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 re‑imprisonment was prior imprisonment (Wundersitz 2010).

Nationally, 77.0 per cent of Aboriginal and Torres Strait Islander prisoners on 30 June 2013 had a known prior imprisonment, with this proportion remaining relatively unchanged over the past 13 years (table 11A.4.1). The proportion of non‑Indigenous prisoners with known prior imprisonment was 50.9 per cent, also relatively unchanged over time (table 11A.4.1).

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| Figure 11.4.1 Proportion of prisoners with known prior adult imprisonment under sentence, by sex, 30 June 2013**a** |
| Figure 11.4.1 Proportion of prisoners with known prior adult imprisonment under sentence, by sex, 30 June 2013  More details can be found within the text surrounding this image. |
| a In the NT, there were no non-Indigenous female prisoners with known prior adult imprisonment at 30 June 2013. |
| *Source*: ABS (2013) *Prisoners in Australia*, 2013, Cat. no. 4517.0; table 11A.4.2. |
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Nationally, 77.9 per cent of Aboriginal and Torres Strait Islander male prisoners had experienced prior adult imprisonment, compared with 67.8 per cent of Aboriginal and Torres Strait Islander female prisoners (figure 11.4.1). The proportion was higher for Aboriginal and Torres Strait Islander male prisoners compared with non‑Indigenous male prisoners (except in the ACT) and Aboriginal and Torres Strait Islander female prisoners compared with non‑Indigenous female prisoners (except in Tasmania) (figure 11.4.1).

### Youth returns to sentenced supervision

The AIHW used national data from the 2011‑12 Juvenile Justice National Minimum Dataset to measure the proportion of young people who return to sentenced supervision over three timeframes:

* within 1 year of a sentenced supervision order, Aboriginal and Torres Strait Islander young people in 2010‑11 returned at 1.3 times the rate of non‑Indigenous young people (51 per cent compared with 40 per cent)
* within 2 years of a sentenced supervision order, Aboriginal and Torres Strait Islander young people in 2009‑10 returned at 1.3 times the rate of non‑Indigenous young people (72 per cent compared with 58 per cent)
* during the entire time for which a young person is eligible to return to youth justice supervision, Aboriginal and Torres Strait Islander young people returned at 1.5 times the rate of non‑Indigenous young people (63 per cent compared with 43 per cent) (AIHW 2013).

Jurisdictional cohort studies measuring longitudinal outcomes of youth offending patterns have been published in previous OID reports.

### Offenders proceeded against more than once by police

An offender can be proceeded against by police multiple times during a given period.

Comparable data are available for NSW, Queensland, SA and the NT. For these jurisdictions in 2012‑13, 40 to 47 per cent of Aboriginal and Torres Strait Islander offenders were proceeded against by police on more than one occasion, compared with 18 to 28 per cent of non‑Indigenous offenders during the reference period (table 11A.4.3).

In 2012-13, Aboriginal and Torres Strait Islander offenders were younger than non‑Indigenous offenders for both males and females in NSW, Queensland, SA and for males in the NT (table 11A.4.4).

### 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 are another means of reducing reoffending. Payne, Kwiatkowski and Wundersitz (2008) studied the outcomes of police drug diversion programs in various jurisdictions and found them to be effective in reducing recidivism, including for entrenched offenders. Box 11.4.3 describes an example of a diversion program, supported by police, magistrates and drug courts, that has shown reductions in recidivism.

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| Box 11.4.3 Things that work — repeat offending |
| 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 Indigenous) with a comparison group of defendants (15 per cent Indigenous) 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. Current priorities include a recidivism data collection project (SCRGSP 2014).

### References

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Wundersitz, J. 2010, *Indigenous perpetrators of violence: Prevalence and risk factors for offending*, Research and Public Policy Series No.105, Australian Institute of Criminology, Canberra.

## 11.5 Community functioning[[6]](#footnote-6)

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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.
* Community functioning scores provide a national quantitative measure of functioning, drawing on Aboriginal and Torres Strait Islander perspectives. In 2008, results showed that, for children aged 0–14 years and for those aged 15 years and over, median community functioning scores were similar across sex and geographic location, reflecting consistent experiences of community functioning.
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| Box 11.5.2 Measures of community functioning |
| There are two main measures for this indicator: * *A summary of findings for each community functioning theme*
* Connectedness to country, land and history; culture and identity
* Resilience
* Leadership
* Having a role, structure and routine
* Feeling safe
* Vitality.
* *Median community functioning scores are* defined as the midpoint of the distribution of weighted scores for each data item under each community functioning theme, for children aged 0–14 years and people aged 15 years or over, with a higher median score indicating stronger community functioning*.*

Findings are sourced from the *Aboriginal and Torres Strait Islander Health Performance Framework* (ATSIHPF) 2012. The ATSIHPF indicator contains multiple measures of family and community life, drawing on data from the ABS National Aboriginal and Torres Strait Islander Social Survey (NATSISS). Data are collected every six years with the most recent data available for 2008 (all jurisdictions; sex; age; remoteness). Time series are not included in this report as some data were not previously available (see future directions in data). |
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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 (social, cultural, spiritual and organisational) and to translate their knowledge, skills, and understanding (capabilities) into positive actions towards a valued life (AIHW 2013). The conversion of capabilities into functioning is influenced by the values and personal characteristics of the individuals, families and communities, and by the environment in which they live. Different cultures will give greater or lesser priority to different aspects of functioning (AHMAC 2012).

### Summary of findings for each community functioning theme

Workshops led by Aboriginal facilitators on behalf of the work program for the ATSIHPF developed the concept and measures with Aboriginal and Torres Strait Islander Australians in 2008 and 2010. Participants identified a number of key themes and weighted these functionings according to their relative value. Whilst the measure covers multiple constructs, these combine to build an overall picture of community functioning for Aboriginal and Torres Strait Islander Australians.

Table 11.5.1 provides a brief description of each theme; its weight as a percentage out of 100; and references to relevant data available in other sections of this report (or a summary of relevant data from the 2008 NATSISS).

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| Table 11.5.1 Summary of findings for community functioning capabilities |
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| **Measure of functioning** | **Weight (per cent)** |
| **Descriptor** | **Findings or relevant OID sections** |
| Connectedness to country, land and history; culture and identity | Weight 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
 | 5 — Governance, leadership and culture* 5.1 Valuing Indigenous Australians and their cultures
* 5.2 Participation in decision making
* 5.7 Participation in community activities
* 5.8 Access to traditional lands and waters

For Aboriginal and Torres Strait Islander Australians in 2008:* 94 per cent had contact with family or friends outside the household at least once per week
* 75 per cent had friends to confide in
* 51 per cent provided support to relatives outside the household
 |
| Resilience | Weight 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
 | 5 — Governance, leadership and culture* 5.1 Valuing Indigenous Australians and their cultures
* 5.7 Participation in community activities

For Aboriginal and Torres Strait Islander Australians in 2008:* 89 per cent felt they were able to find general support from outside the household
* 56 per cent had provided support to someone outside their household in the last four weeks
* 54 per cent (in non-remote areas) knew someone in an organisation they would feel comfortable contacting
 |
| Leadership | Weight 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
 | 5 — Governance, leadership and culture* 5.4 Case studies in governance.

For Aboriginal and Torres Strait Islander Australians in 2008:* 42 per cent of children aged 3 to 14 years had spent time with an Indigenous leader or Elder in the last week.
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| Table 11.5.1 (continued) |
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| **Measure of functioning** | **Weight (per cent)** |
| **Descriptor** | **Findings or relevant OID sections** |
| Having a role, structure and routine | Weight 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
 | For Aboriginal and Torres Strait Islander Australians in 2008:* 78 per cent had lived in only one dwelling in the last 12 months
* 73 per cent were in households that had not experienced cash flow problems in the last 12 months
* 86 per cent were in households in which there had been no days without money for basic living expenses in the last two weeks
* 94 per cent of children aged 0 to 14 years had participated in informal learning activities with their main carer.
 |
| Feeling safe | Weight 10 per cent |
| * Lack of physical and lateral violence
* Safe places
* Emotional security
* Cultural competency
* Relationships that can sustain disagreement
 | For Aboriginal and Torres Strait Islander Australians in 2008:* 75 per cent had not experienced physical and/or threatened violence in the last 12 months
* 80 per cent felt safe at home alone after dark
* in the five years prior to the survey, 97 per cent had not been incarcerated (91 per cent had never been incarcerated in their lifetime).
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| Vitality | Weight 10 per cent |
| * Infrastructure of community
* Access to services
* Education
* Health
* Income
* Employment
 | * 5.3 Engagement with services
* 4.3 Early childhood education
* 4.4 Reading, writing and numeracy
* 4.5 Year 12 attainment
* 4.7 Post-secondary education — participation and attainment
* 8 — Healthy lives
* 4.8 Disability and chronic disease
* 4.9 Household and individual income
* 4.6 Employment
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 |
| *Source*: AHMAC (2012) *Aboriginal and Torres Strait Islander Health Performance Framework 2012 Report*. |
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### Median community functioning scores

The ATSIHPF (AHMAC 2012) reports the distribution of the calculated community functioning scores (this is one element of ATSIHPF’s multi-measure analysis). Median scores are included in this report to show the middle of a distribution. The greater the score, the higher the level of community functioning.

The scores for Aboriginal and Torres Strait Islander children aged 0–14 years (ranging from 0 to 40) are not directly comparable to scores for those aged 15 years or over (ranging from 0 to 70), due to differences in the items used to create the scores, which in turn affect the results.

The median level of community functioning was not affected by age, sex or remoteness. The small variation in median scores is unlikely to be statistically significant.

* Among Aboriginal and Torres Strait Islander Australians aged 15 years or over, the median score ranged from 42 to 45 (table 11A.5.1). The median score was 44 for males and 43 for females. The median score ranged from 43 in regional areas to 45 in very remote areas and ranged from 42 in NSW to 49 in the ACT) (table 11A.5.2).
* Among Aboriginal and Torres Strait Islander children aged 0–14 years, the median score was 20 for boys and 21 for girls. The median score ranged from 20 in non-remote areas to 23 in remote areas, and ranged from 19 in Victoria and Tasmania to 23 in the NT (table 11A.5.2).

### Things that work

Several programs aim to improve general community functioning. 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 by Adelaide-based Aboriginal and Torres Strait Islander Australians and has been integrated into health and human service provision in northern Australia, including into community health promotion, school curricula, welfare reform wellbeing centres and primary health care programs in several states and the Northern Territory. It is a cultural healing program that aims to enhance the capacity of participants to deal with the day-to-day stresses of life and to help others. It uses a group format, in which the experiences of the facilitators and participants are the main learning resource. The program consists of four stages, each lasting 10 weeks. Participants attend one 3-hour session each week (Tsey et al. 2009 cited in CTGCH 2013). The program has been nationally accredited to provide participants with formal qualifications in counselling (Tsey and Every 2000). |
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| Box 11.5.3 (continued) |
| 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.)  |
| *Source*: 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; CTGCH (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 measures for this indicator are only available every six years, with the next available data from the 2014-15 NATSISS anticipated for release in early 2016. Following publication of the 2014-15 data, an assessment of the utility of these measures for time series reporting will be required. Limited data were available for the key theme of leadership though it is anticipated that this measure will continue to develop as new data become available.

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1. The Steering Committee notes its appreciation to the National Indigenous Drug and Alcohol Committee, which reviewed a draft of this section of the report. [↑](#footnote-ref-1)
2. The Steering Committee notes its appreciation to the National Indigenous Drug and Alcohol Committee, which reviewed a draft of this section of the report. [↑](#footnote-ref-2)
3. 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-3)
4. 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-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)