Submission to the Inquiry into the Harmful Use of Alcohol in Aboriginal and Torres Strait Islander Communities

April, 2014

NATSILS
NATIONAL ABORIGINAL & TORRES STRAIT ISLANDER LEGAL SERVICES

Human Rights Law Centre

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1. About NATSILS

The National Aboriginal and Torres Strait Islander Legal Services (NATSILS) is the peak national body for Aboriginal and Torres Strait Islander Legal Services (ATSILS) in Australia. NATSILS brings together over 40 years' experience in the provision of legal advice, assistance, representation, community legal education, advocacy, law reform activities and prisoner through-care to Aboriginal and Torres Strait Islander peoples in contact with the justice system. NATSILS are the experts on the delivery of effective and culturally competent legal assistance services to Aboriginal and Torres Strait Islander peoples. This role also gives us a unique insight into access to justice issues affecting Aboriginal and Torres Strait Islander peoples. The NATSILS represent the following ATSILS:

- Aboriginal and Torres Strait Islander Legal Service (Qld) Ltd (ATSILS Qld);
- Aboriginal Legal Rights Movement Inc. (ALRM);
- Aboriginal Legal Service (NSW/ACT) (ALS NSW/ACT);
- Aboriginal Legal Service of Western Australia (Inc.) (ALSWA);
- Central Australian Aboriginal Legal Aid Service (CAALAS);
- North Australian Aboriginal Justice Agency (NAAJA); and
- Victorian Aboriginal Legal Service Co-operative Limited (VALS).

2. About the HRLC

The Human Rights Law Centre (HRLC) protects and promotes human rights in Australia and beyond through a strategic mix of legal action, evidence-based advocacy, education and capacity building. It is an independent, non-government and not-for-profit organisation.

The HRLC works in coalition with key partners, including community organisations, law firms and barristers, academics and experts, and international and domestic human rights organisations.

3. Executive Summary

Alcohol abuse and alcohol-related harm is a nationwide problem in Australia, and not just in Aboriginal and Torres Strait Islander communities. Alcohol abuse is both a cause and consequence of major public health issues and it is clear that better strategies need to be adopted to address the underlying causes of alcohol-related harm.

Alcohol misuse and related harm has clear social and economic determinants and is closely related to disadvantage. As such, Aboriginal and Torres Strait Islander communities which rate disproportionately high in all measures of disadvantage, experience higher rates of alcohol misuse and related harm. Due to gaps in the available research, the exact extent to which this occurs is difficult to say.

Across the criminal justice system, the health system, productivity levels and traffic accidents, the prevalence and impact of alcohol misuse and related harm is high and comes

at a significant cost to Australia. Higher levels of alcohol-related harm among Aboriginal and Torres Strait Islander peoples are reflected in data on hospital admissions, deaths, homicides and rates of Foetal Alcohol Syndrome (FAS) and Foetal Alcohol Spectrum Disorders (FASD). The impacts are felt beyond individual drinkers, and are experienced by their families and communities more broadly. Protection against alcohol-related harm must be a priority, however, overall, the best way to protect people is to stop alcohol misuse and related harm and prevent them from becoming victims in the first place.

There is a significant amount of evidence, and much consensus, in regards to effective strategies to reduce alcohol misuse and alcohol-related harm. Coordinated approaches which address supply, demand and harm minimisation have proven to be the most effective, as reflected in the National Drug Strategy 2010-2015. While others are better placed to advise on the specifics of these strategies, this submission includes a concise overview of the most effective strategies. As this is not our core area of expertise, NATSILS and the HRLC direct the Inquiry to research and submissions by the National Indigenous Drug and Alcohol Committee and the Aboriginal Peak Organisations Northern Territory, among other experts in the sector, for further advice.

Where NATSILS and the HRLC are best placed to provide comment is in regards to the relationship between alcohol misuse and related harm and the criminal justice system. In our experience, the criminal justice system is an inappropriate, ineffective and harmful way to address issues of alcohol misuse and related harm. Current criminal justice approaches, such as the criminalisation of public drunkenness and other alcohol related offences and a lack of diversion to treatment options are not effective ways to address the causes of alcohol abuse and often exacerbate the underlying issues. They result in the criminalisation of a major public health issue and contribute to the over-incarceration of Aboriginal and Torres Strait Islander people. Criminalisation does nothing to address alcoholism and the police and courts are ill-equipped to tackle such complex social and health issues. Out of all the evidence available as to what strategies have been proven to reduce alcohol misuse and related harm, it is clear that criminalisation is not one of them.

4. Recommendations

RECOMMENDATION 1

A human rights framework must guide the development of laws, policies and practices to address alcohol use and abuse in Aboriginal and Torres Strait Islander peoples, including in particular the recognition that alcohol abuse is a right to health issue. This includes taking appropriate steps to ensure the availability, accessibility, acceptability and quality of holistic health care facilities, services and programs for all Aboriginal and Torres Strait Islander communities.

RECOMMENDATION 2

Measures to address alcohol abuse and alcohol-related harm must not be discriminatory but rather tailored to suit the needs of specific communities. In this respect, the measures designed must involve the participation of affected communities to ensure that they are culturally appropriate, address community needs and have the greatest chance of success.

RECOMMENDATION 3

Strategies to address alcohol misuse and alcohol-related harm must be primarily focused on addressing the underlying social and economic determinants of misuse and harm and on ending intergenerational trauma.

RECOMMENDATION 4

That Australian Governments implement an evidence based, nationally coordinated and resourced approach to addressing the prevalence and impact of Foetal Alcohol Spectrum Disorder that reflects the views of relevant experts such as the National Indigenous Drug and Alcohol Committee.

RECOMMENDATION 5

That Australian Governments implement an evidence based, nationally coordinated and resourced approach to addressing harmful alcohol use and alcohol-related harm that reflects the National Drug Strategy 2010-2015 and the views of relevant experts such as the National Indigenous Drug and Alcohol Committee.

RECOMMENDATION 6

That all Australian Governments recognise in legislation, policy and practice the principle that alcohol misuse and alcohol-related harm is a public health issue and that criminal justice approaches are an inappropriate, ineffective and harmful means of addressing such.

RECOMMENDATION 7

That public drunkenness is decriminalised in all Australian jurisdictions and that such is accompanied by increased investment in the provision of appropriate services, including sobering up centres and training of police and health care staff.

RECOMMENDATION 8

That criminal offences related to the possession or use of alcohol, or absconding from an alcohol treatment program, be removed.

RECOMMENDATION 9

That diversionary treatment programs for alcohol related offending, which are culturally competent for Aboriginal and Torres Strait Islander peoples, inclusive of family members and community supports, are expanded and provided in regional and remote areas in recognition of the fact that addressing an individual's alcohol misuse and dependence issues is a more effective means of rehabilitation.

RECOMMENDATION 10

That the criminal justice system develop better screening processes in order to identify and assess people affected by Foetal Alcohol Spectrum Disorder so that such can inform their treatment before the courts.

RECOMMENDATION 11

That increased investment is made in appropriate community support services so that people with disability, cognitive impairment and mental illness, including Foetal Alcohol Spectrum Disorder, can be appropriately diverted away from the criminal justice system.

5. A human rights framework

5.1 Relevance of human rights

Alcohol abuse and alcohol-related harm raises a number of human rights issues. In addition to alcohol abuse limiting the capacity of individuals to obtain the highest level of physical and mental health, alcohol-related harm causes damage to individuals and communities and impacts on the realisation of a range of other human rights, including the right to life, freedom from violence and the rights of women and children.

Australia has ratified a number of key international human rights treaties that impose legal obligations on Australia to respect, protect and fulfil the human rights set out in those treaties. In a federal system like Australia, these legal obligations apply to federal, state and local governments. Public or governmental authorities at all levels must act to respect, protect and fulfil human rights.[1]

This section of the submission outlines a number of human rights that are particularly relevant to the use of alcohol in Aboriginal and Torres Strait Islander communities, namely:

- the right to health;
- the right to equality and non-discrimination;
- the rights of Aboriginal and Torres Strait Islander peoples; and
- the rights of victims .

5.2 The right to health

Health is a fundamental human right that is indispensable for the exercise of other human rights. The right to health is closely related to and dependent upon the realisation of other

[1] UN Human Rights Committee, *General Comment 31: Nature of the General Legal Obligation Imposed on States Parties to the Covenant*, UN Doc CCPR/C/21/Rev.1/Add13 (2004), [4]. See also art 50 of the ICCPR and art 27 of the Vienna Convention on the Law of Treaties, which provides that a state party 'may not invoke the provisions of its internal law as justification for its failure to perform a treaty'.

human rights, including the rights to housing, work, education, life, and equality and non-discrimination.

The right to health is recognised in numerous international instruments, including article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR). Article 12(1) protects "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health", while article 12(2) outlines, by way of illustration, a number of "steps to be taken by the States parties ... to achieve the full realization of this right".[2]

In its General Comment No 14, the UN's Committee on Economic, Social and Cultural Rights ("UN Committee") provides a useful overview of the normative content of the right to health to assist States parties' such as Australia.[3] Most usefully, the Committee outlines the following essential elements of the right to health:[4]

- *availability* of public health and health-care facilities, goods, services and programs;
- *accessibility* of health facilities, goods and services to everyone without discrimination, which has four overlapping dimensions:
    - non-discrimination;
    - physical accessibility;
    - economic accessibility (that is, affordability); and
    - information accessibility;
- *acceptability* of health facilities, goods, services and programs, which includes being culturally appropriate; and
- *quality* of health facilities, goods, services and programs, in addition to being culturally appropriate.

These elements provide an important framework and useful guidance in determining what action is to be taken by governments to develop services and programs to address alcohol misuse and promote the right to health.

Specifically in relation to Indigenous peoples, the UN Committee observes that particular measures to improve access to health services and health care need to be taken.[5] Health services should be culturally appropriate, and resources should be provided for Indigenous peoples to design, deliver and control such services so that they may enjoy the highest attainable standard of physical and mental health. Importantly, the UN Committee also

[2] The right to health is recognised in a range of other human rights treaties to which Australia is a party, including article 5(e)(iv) of the International Convention on the Elimination of All Forms of Racial Discrimination, in articles 11 and 12 of the Convention on the Elimination of All Forms of Discrimination against Women and in article 24 of the Convention on the Rights of the Child.

[3] Committee on Economic, Social and Cultural Rights, General Comment No. 14: The right to the highest attainable standard of health (2000), UN Doc E/C.12/2000/4, para 3.

[4] Ibid, [12]

[5] Ibid, [27].

notes that, in Indigenous communities, "the health of the individual is often linked to the health of the society as a whole and has a collective dimension".[6]

5.3 Equality and non-discrimination

The rights to non-discrimination and to substantive equality are fundamental components of human rights law that are entrenched in a wide range of human rights treaties.[7] Equality and non-discrimination constitute basic and general principles relating to the protection of all human rights.[8]

Equality of access to health care and health services is an essential element of the right to health. More broadly, ensuring substantive equality for Aboriginal and Torres Strait Islander peoples in all aspects of their lives is also essential for the full enjoyment of the right to health.

The significant gap in health outcomes between Aboriginal and Torres Strait Islander peoples and non-Aboriginal and Torres Strait Islander people in Australia means that particular steps will need to be taken to ensure that Aboriginal and Torres Strait Islander peoples can access health services and programs on an equal basis and that health equality is achieved. Governments have a special obligation to provide those who do not have sufficient means with the necessary health services and programs, and to prevent any discrimination in the provision of health care and health services.[9] The UN Committee also warns that inappropriate health resource allocation can lead to discrimination that may not be overt.[10]

5.4 Rights of Aboriginal and Torres Strait Islander Peoples

In addition to the human treaties to which Australia is a party, Australia has also indicated its formal support for the UN Declaration on the Rights of Indigenous Peoples (Declaration).[11] The Declaration was adopted by the United Nations General Assembly in 2007 and is a landmark document that recognises the fundamental human rights of Indigenous peoples around the world on a wide range of issues.

While the Declaration is not, strictly, legally binding, it is a significant instrument that establishes a framework for the human rights that already exist in international law and their specific application to Indigenous peoples. In this respect, the Declaration has "significant moral force"[12] and represents an important standard for the treatment of Indigenous peoples.

The Declaration establishes a framework for the human rights that already exist in international law and their specific application to Indigenous peoples. Most significantly,

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[6] Ibid.

[7] See, for example, arts 2 and 26 of the ICCPR; art 2 of ICESCR; art 2 of CEDAW; arts 2 and 5 of CERD; art 2 of CRC and art 5 of the CRPD.

[8] UN Human Rights Committee, *General Comment No. 18: Non-discrimination (Thirty-seventh session, 1989), Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, UN Doc HRI/GEN/1/Rev.6 (2003) at 146.

[9] General Comment No 14, [19].

[10] Ibid.

[11] UN GAOR, 61st session, GA Res 61/295, UN Doc A/RES/47/1 (2007).

[12] M Davis, *The United Nations Declaration on the Rights of Indigenous Peoples* (2007) 11(3) AILR 55, 55.

however, the Declaration outlines a number of key “guiding principles” which underpin the rights contained within it:[13]

- *self-determination;*
- *participation in decision-making and free, prior and informed consent;*
- *respect for and protection of culture; and*
- *non-discrimination and equality.*

Australia’s endorsement of the Declaration represents an important acknowledgement of the fundamental human rights of Aboriginal and Torres Strait Islander peoples in Australia and the need for recognition of specific collective rights. Compliance with international human rights obligations is crucial in order to address the serious disadvantage and discrimination that is experienced by many Aboriginal and Torres Strait Islander peoples.

RECOMMENDATION 1

A human rights framework must guide the development of laws, policies and practices to address alcohol use and abuse in Aboriginal and Torres Strait Islander peoples, including in particular the recognition that alcohol abuse is a right to health issue. This includes taking appropriate steps to ensure the availability, accessibility, acceptability and quality of holistic health care facilities, services and programs for all Aboriginal and Torres Strait Islander communities.

RECOMMENDATION 2

Measures to address alcohol abuse and alcohol-related harm must not be discriminatory but rather tailored to suit the needs of specific communities. In this respect, the measures designed must involve the participation of affected communities to ensure that they are culturally appropriate, address community needs and have the greatest chance of success.

[13] These principles have been identified by the Australia’s Aboriginal and Torres Strait Islander Social Justice Commissioner in his Social Justice Report 2011, available at http://www.hreoc.gov.au/social_justice/sj_report/sjreport11/index.html.

6. Patterns of supply of, and demand for, alcohol

There is some difficulty in obtaining the necessary data to accurately determine patterns of supply of, and demand for, alcohol in different Aboriginal and Torres Strait Islander communities, age groups and genders. The main source of data on alcohol consumption in the general community is the National Drug Strategy Household Survey (NDSHS) which includes representative data from persons 12 years or older. NDSHS reports statistics on the frequency and intensity of drinking, particular patterns of drinking, drinking by level or risk, and a range of demographic, economic and social characteristics of respondents. However, as the National Indigenous Drug and Alcohol Committee has noted,[14] because it does not include data from persons who are imprisoned or homeless, and there is a tendency for respondents to underestimate their drinking, the survey results tend to underestimate the true prevalence of alcohol consumption in Australia.

The 2010 NDSHS shows Aboriginal and Torres Strait Islander people were 1.4 times more likely than non-Aboriginal and Torres Strait Islander people to abstain from drinking alcohol, but were also about 1.5 times more likely to drink alcohol at risky levels for both single occasion and lifetime harm.

Additional research by the Australian Institute of Health and Welfare states that:[15]

- Around 23 percent of Aboriginal and Torres Strait Islander peoples do not currently drink alcohol compared with 17 percent of non-Aboriginal and Torres Strait Islander people;

- Available data broadly indicates that between 1993 and 2007 the prevalence of alcohol use among non-Aboriginal and Torres Strait Islander people increased by 14 percent while among Aboriginal and Torres Strait Islander people it increased by 24 percent;

- Around 20 percent of non-Aboriginal and Torres Strait Islander people consume alcohol in a manner that poses short-term risks to their health—usually in the form of heavy episodic consumption or 'binge drinking'. In addition, a further 10 percent drink at levels which pose long-term health risks;

- As a consequence of methodological issues relating to sampling and the questions posed, it is difficult to estimate levels of risky drinking among Aboriginal and Torres Strait Islander peoples; and

- However, the available data suggest that the pattern of heavy episodic drinking or 'binge drinking' is more marked among Aboriginal and Torres Strait Islander peoples, and that the prevalence of consumption that poses both short- and long-term risks to health is about double that of the non-Aboriginal and Torres Strait Islander population.

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[14] National Indigenous Drug and Alcohol Committee, *Addressing fetal alcohol spectrum disorder in Australia* (2012) at http://www.nidac.org.au/images/PDFs/NIDACpublications/FASD.pdf , 3.

[15] Australian Institute of Health and Welfare, *Reducing alcohol and other drug related harm* (2010), 2-3.

7. The social and economic determinants of harmful alcohol use

There is strong evidence of an association between social determinants such as unemployment, homelessness, poverty, and family breakdown and alcohol use.[16] The Australian Institute of Health and Welfare has found that:[17]

- The health of individuals and populations is largely determined by social and economic factors, which can both protect against or increase the risk of ill health or harmful alcohol use;
- A review of the evidence, conducted for the World Health Organization, found a clear link between socioeconomic deprivation and risk of dependence on alcohol;
- On all social indicators, Aboriginal and Torres Strait Islander peoples are disadvantaged compared with non-Aboriginal and Torres Strait Islander people;
- As among Indigenous populations elsewhere, socio-economic disadvantage is a consequence of the historical and *continuing* impact of colonialism and dispossession, which has left many impoverished, marginalised, discriminated against, in a state of poor physical and mental health, and with inequitable access to necessary public and private services, particularly education, health and employment;
- Higher levels of harmful alcohol use are one consequence of the trauma caused by this; and
- In turn, higher levels of alcohol use further contribute to poor health status and social disruption.

These findings, as well as evidence that higher levels of income, employment, participation in education, family stability and housing stability are protective factors against harmful alcohol use,[18] indicate that it is necessary to address the underlying social determinants to 'close the gap' as well as implement strategies that directly target alcohol misuse and alcohol-related harm itself.

RECOMMENDATION 3 Strategies to address alcohol misuse and alcohol-related harm must be primarily focused on addressing the underlying social and economic determinants of misuse and harm and on ending intergenerational trauma.

[16] National Drug Strategy 2010-2015, 6.
[17] Australian Institute of Health and Welfare, *Reducing alcohol and other drug related harm* (2010), 2.
[18] National Drug Strategy 2010-2015, 6; Australian Institute of Health and Welfare, *Reducing alcohol and other drug related harm* (2010), 2.

8. Trends and prevalence of alcohol related harm

The prevalence of alcohol-related harm is high and comes at a significant cost to Australia. The Australian Institute of Criminology found that the total cost to Australian society of alcohol-related harm in 2010 was estimated to be $14,352 billion.[19] Of this,

- $2,958 billion (or 20.6 percent) represented costs to the criminal justice system;
- $1,686 billion (or 11.7 percent) comprised costs to the health system;
- $6,046 billion (or 42.1 percent) involved costs to Australian productivity; and
- $3,662 billion (or 25.5 percent) were costs associated with traffic accidents.

This estimate of total costs, however, does not incorporate the negative impacts on others associated with someone else's drinking which has been estimated at $6,807 billion.[20]

Alcohol misuse can cause harm in many different ways. For example, the National Drug Strategy 2010-2015 states that:

> The excessive consumption of alcohol is a major cause of health and social harms. Short episodes of heavy alcohol consumption are a major cause of road and other accidents, domestic and public violence, and crime. Long-term heavy drinking is a major risk factor for chronic disease, including liver disease and brain damage, and contributes to family breakdown and broader social dysfunction. Drinking during pregnancy can cause birth defects and disability, and there is increasing evidence that early onset of drinking during childhood and the teenage years can interrupt the normal development of the brain.[21]

As well as health problems, alcohol misuse is the cause of a wide range of social problems and contributes to the high rates of Aboriginal and Torres Strait Islander unemployment and incarceration. It also has significant impacts on people other than the users themselves. Of particular concern are the negative impacts of violent antisocial behaviour and parental alcohol use on unborn children, children and adolescents and the intergenerational impacts of these. Whether they use alcohol or not, nearly all Aboriginal and Torres Strait Islander peoples are impacted by alcohol misuse and alcohol-related harm in some way.

Higher levels of alcohol-related harm among Aboriginal and Torres Strait Islander peoples are reflected in data on hospital admissions, deaths, homicides and rates of Foetal Alcohol Syndrome (FAS) and Foetal Alcohol Spectrum Disorders (FASD):

- Aboriginal and Torres Strait Islander men are hospitalised for conditions, to which alcohol makes a significant contribution, at rates between 1.2 and 6.2 times those of non-Aboriginal and Torres Strait Islander men, and Aboriginal and Torres Strait

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[19] Matthew Manning, Christine Smith and Paul Mazerolle, Australian Institute of Criminology, *The societal costs of alcohol misuse in Australia* (2013), *3.*

[20] Laslett A et al, *The range and magnitude of alcohol's harm to others* (2010).

[21] National Drug Strategy 2010-2015, 2.

Islander women at rates between 1.3 and 33 times greater (in the latter case for assault injuries);[22]

- Similarly, deaths of Aboriginal and Torres Strait Islander peoples from alcohol-related causes are 5 to 19 times greater than among non-Aboriginal and Torres Strait Islander peoples;[23]

- 71.4 percent of Aboriginal and Torres Strait Islander homicides over the period 1999-2000 to 2008-09 involved both the victim and offender having consumed alcohol at the time of the offence, compared with 24.7 percent of non-Aboriginal and Torres Strait Islander homicides; and[24]

- The prevalence of FAS and FASD in Australia is somewhat difficult to determine, as there is a lack of accurate research data across all population groups as well as confusion between FAS and FASD. Nevertheless, The Foundation for Alcohol Research and Education (FARE) in its submission to the Commonwealth Inquiry into Foetal Alcohol Spectrum Disorders reported that recent research estimates the prevalence of FAS to be between 0.06 and 0.68 per 1 000 live non-Aboriginal and Torres Strait Islander births and between 2.76 and 4.7 per 1 000 Aboriginal and Torres Strait Islander births. Other experts consider this to be a significant underestimation.[25]

9. The implications of Foetal Alcohol Syndrome and Foetal Alcohol Spectrum Disorders being declared disabilities

9.1 What is Foetal Alcohol Syndrome and Foetal Alcohol Spectrum Disorders

The term ‘foetal alcohol spectrum disorder’ (FASD) is an umbrella term to describe a range of adverse effects, which include the diagnostic terms ‘foetal alcohol syndrome’ (FAS), ‘partial foetal alcohol syndrome’ (PFAS), ‘alcohol-related neurodevelopmental disorders’ (ARND), ‘foetal alcohol effects’ (FAE), or ‘alcohol-related birth defects’ (ARBD), caused by prenatal exposure to alcohol.[26] Children, youth and adults with FASD may present with a range of symptoms and impairments in development, learning and behaviour. Some of the symptoms may be present in early childhood, while other symptoms may be recognised only after the commencement of formal education. Children displaying the complete array of characteristic facial anomalies, growth retardation and developmental abnormalities of the

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[22] Australian Institute of Health and Welfare and the Australian Bureau of Statistics, *The health and welfare of Australia’s Aboriginal and Torres Strait Islander peoples* (2008).

[23] Steering Committee for the Review of Government Service Provision, *Overcoming Indigenous Disadvantage: key indicators 2009* (2009).

[24] Steering Committee for the Review of Government Service Provision, Overcoming Indigenous Disadvantage: key indicators 2011 (2011), 10.3.

[25] The Foundation for Alcohol Research and Education, *Submission to the House of Representatives Committee on Social Policy and Legal Affairs Inquiry into Fetal Alcohol Spectrum Disorders* (2012), 8, 17.

[26] National Organisation for Fetal Alcohol Spectrum Disorders at http://www.nofasard.org/

central nervous system are defined as having FAS.[27] FASD is entirely preventable and, if children are assessed and diagnosed early in life, it is also potentially treatable. If not prevented or diagnosed early, the condition can have a profound lifelong impact, initiating or perpetuating a cycle of intergenerational disadvantage and poor health. The prevalence of FASD in Australia is presented in section 5 above.

It is important to note that FASD is not a problem unique to Aboriginal and Torres Strait Islander peoples or to Indigenous people generally. While in some parts of Australia and overseas, particularly in Canada and the United States, prevalence estimates of FAS in Indigenous communities are higher than that reported for the wider community, most researchers agree that the difference reflects other factors such as socioeconomic status, drinking patterns and differences in diet rather than racial characteristics.[28] Also, most studies of FASD in Indigenous communities have been undertaken in communities that are already known to have high levels of alcohol consumption, and hence, it is difficult to apply the findings of such studies to other Indigenous communities or Indigenous populations as a whole.

9.2 Social and economic costs

The social impact of FASD in Australia is believed to be significant and far-ranging. The economic costs associated with FASD in Australia are unknown. We can however, look to other comparable jurisdictions for a guide as to what the social and economic costs of FASD might be in Australia.

An American study conducted with individuals with FAS/FAE aged between 6 years and 51 years found that:[29]

- 90 per cent had mental health problems such as cognitive disorders, psychiatric illness or psychological dysfunction (6 years and over)
- 30 per cent had alcohol and other drug use issues (12 years and over)
- 60 per cent had disrupted school experience (12 years and over), and
- 50 per cent exhibited inappropriate sexual behaviour (12 years and over).

This study found other social issues facing individuals with FASD included:

- early maternal death
- living with a parent who has alcohol abuse problems
- child abuse and neglect
- removal from the home by children's protective services
- repetitive periods of foster care and other transient home placements

[27] National Indigenous Drug and Alcohol Committee, *Addressing fetal alcohol spectrum disorder in Australia* (2012), 1.
[28] Ibid, 9.
[29] Streissguth, AP et al, 'Risk factors for adverse life outcomes in fetal alcohol syndrome and fetal alcohol effects' (2004) *Journal of Developmental and Behavioral Pediatrics* 25(4): 228–238.

- being raised by adoptive or foster parents
- victims of discrimination

The impact on families, the health care system, the social service system, the criminal justice system, and the education and employment systems was also found to have been significant.

As to economic costs, a study conducted in Canada examined key cost components associated with FASD.[30] These included direct costs such as medical, education, social services, and out-of-pocket expenses, as well as indirect costs such as productivity losses. The estimated annual costs associated with FASD per person were over $21,000 CAD. Costs of FASD to the Canadian community from birth to 53 years old were estimated at $5.3 billion CAD each year.

Further discussion of the impact and costs of FASD in terms of the relationship between people affected by FASD and contact with the criminal justice system is included later in this submission.

9.3 Diagnosis

Critical to preventing or at least ameliorating adverse outcomes for people with FASD is early diagnosis. Early diagnosis enables intervention strategies to be implemented which could prevent or greatly reduce the development and impact of secondary disabilities, including mental illness, alcohol and other drug issues, and interaction with the criminal justice system.

However, there is currently no single internationally accepted diagnosis tool for FASD and no standardised screening test exists in Australia.[31] FASD is not well detected both generally and specifically among Aboriginal and Torres Strait Islander peoples. Cases of even full-blown foetal alcohol syndrome often go undetected at birth and later in life and children with less severe anomalies typical in the FASD continuum present an even greater diagnostic challenge, because often the physical signs are more subtle.[32] One barrier to diagnosing FASD relates to the difficulties in confirming prenatal maternal alcohol use. This constitutes an essential criteria in diagnosing FASD, however is often not well-documented and doctors are unable to rely on hearsay evidence about alcohol consumption to make a diagnosis.[33] Additionally, issues arise due to the absence of multi-disciplinary teams who can contribute to FASD diagnosis.

9.4 Disability status

FASD is not currently a recognised disability in Australia for the purpose of families and carers being able to access government financial assistance. Individuals with FASD have a range of special needs and require a variety of sometimes intensive support throughout their lifetime. Caring for children, and indeed adults, with FASD can be all-consuming and difficult, and early intervention strategies can be expensive. Financial assistance is critical if

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[30] Stade, B et al, 'The burden of prenatal exposure to alcohol: revised measurement of cost' (2009) *Canadian Journal of Clinical Pharmacology* 16(1): e91–e102.

[31] National Indigenous Drug and Alcohol Committee, *Addressing fetal alcohol spectrum disorder in Australia* (2012), 11.

[32] Aboriginal Peak Organisations Northern Territory, *Submission to the Australian House of Representatives Standing Committee on Social Policy and Legal Affairs Inquiry into Foetal Alcohol Spectrum Disorder* (2011), 20-19.

[33] Ibid, 20-19.

children with FASD are going to be able to access the critical early intervention strategies that can help manage the adverse impact of FASD.

The Commonwealth Inquiry into Foetal Alcohol Spectrum Disorder[34] considered in depth the question of access to support services for people with FASD and its classification as a recognised disability. The Inquiry reported that currently, access to government financial assistance is unpredictable and unclear for individuals with FASD and their carers[35] and that including FASD on the List of Recognised Disabilities and defining disability to include cognitive impairment would enhance access for people with FASD.[36]

RECOMMENDATION 4

That Australian Governments implement an evidence based, nationally coordinated and resourced approach to addressing the prevalence and impact of Foetal Alcohol Spectrum Disorder that reflects the views of relevant experts such as the National Indigenous Drug and Alcohol Committee.

10. Best practice treatments and strategies to minimise alcohol misuse and alcohol-related harm

NATSILS and HRLC core expertise lies in the relationship between harmful alcohol use and related harm and the justice system (which is discussed later in this submission) as well as the human rights impact of alcohol misuse and related harm. We recognise that there are others who are better placed to advise on the most effective treatments and strategies to minimise alcohol misuse and alcohol-related harm. As such, we look to the experts and the evidence and support the three pillar approach advocated for by the National Indigenous Drug and Alcohol Committee, which is largely reflected in the National Drug Strategy 2010-2015. This approach focuses on demand, supply and harm reduction with a particular focus on the need for community control and empowerment throughout. No one strategy on its own can prevent and reduce the demand for, and harmful consumption of, alcohol. Rather, broad-based, multidisciplinary and flexible strategies are needed to meet the varied needs of individuals and communities.

Given the expertise of others in this area who will be making more detailed submissions to the Inquiry about these issues, we will only include a brief overview of the evidence as to the effectiveness of different strategies and would encourage the Inquiry to look to the National Indigenous Drug and Alcohol Committee, as well as the Aboriginal Peak Organisation Northern Territory, for further information.

10.1 Community controlled measures

The evidence supports the fact that community controlled health measures are more effective in delivering health outcomes. The National Drug and Research Institute has reported, for example, that "in general, restrictions which are imposed on communities will be less effective – in both the short and the long-term – than those which have community

[34] House Standing Committee on Social Policy and Legal Affairs, *FASD: The Hidden Harm - Inquiry into the prevention, diagnosis and management of Fetal Alcohol Spectrum Disorders* (2012).
[35] Ibid, 50.
[36] Ibid, 51.

backing and control."[37] Further, the National Drug and Research Institute commented that a range of measures will usually be needed to address alcohol harm, and the most effective mix of strategies will depend on the needs of each community.[38]

10.2 Demand reduction

In regards to effective demand reduction strategies the evidence shows that:

- On their own, health education and alcohol awareness interventions have limited impact. Thus, while they have a role to play, it is important that these strategies not be used in isolation but rather as part of a multi-faceted approach.

- Treatment, including community based or residential treatment, early intervention, diversion and community-based counselling must address the multi-faceted causes of alcohol misuse and dependence.

- In relation to Aboriginal and Torres Strait Islander peoples in particular, treatment services must also be culturally appropriate and provided locally. Requiring Aboriginal and Torres Strait Islander peoples to move away from family and friends to places where they do not know anybody acts as a deterrent and leads to people not entering rehabilitation, disengaging and absconding.

- Indicators should be developed to assess effectiveness of programs reducing alcohol related harms (e.g., hospitalisations) and contact with the criminal justice system for alcohol related offences.

- There is very little research on the effectiveness of coerced treatment for offenders with chronic alcohol dependence.[39] Mandatory treatment statutes have largely fallen into disuse because of pessimism on the part of magistrates and treatment staff about the effectiveness of compulsory treatment for alcohol dependence.[40]

- While treatment is effective, alcohol dependence is a chronic relapsing condition and it is not realistic to expect that one program of treatment will result in long-term abstinence or controlled use.[41] Ongoing or follow-up care is essential and has been shown to reduce the frequency of relapse.[42]

- Primary health care providers should be resourced to undertake an expanded role in prevention of harmful alcohol misuse and the identification and treatment of alcohol dependent people.

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[37] National Drug and Research Institute at http://ndri.curtin.edu.au/local/docs/pdf/publications/R207.pdf, xvi.
[38] Ibid, xvii.
[39] Wayne Hall, *The Role of Legal Coercion in the Treatment of Offenders with Alcohol and Heroin Problems* (1997), 8.
[40] Ibid.
[41] Australian Institute of Health and Welfare, *Reducing alcohol and other drug related harm* (2010), 6.
[42] McLellan AT, 'Have we evaluated addiction treatment correctly? Implications from a chronic care perspective', *Addiction 97 (3), 249-52.*

- There has been little formal evaluation of 'dry community' or restricted areas legislation in Australia. Typically, dry areas are only really feasible to set up and maintain in more isolated communities. What research is available however, suggests that the best results for dry community declarations are achieved by plans that have been initiated by Aboriginal and Torres Strait Islander communities themselves.

- Systems that restrict access to alcohol for those that misuse it, such as permit system in Nhulunbuy, East Arnhem Land and Groote Eylandt and the Banned Drinkers Register previously in place across the Northern Territory can be successful in reducing alcohol misuse and related harm. [43]

- Alcohol advertising has a significant effect on the incidence of alcohol-related problems[44] and that partial or complete bans on the advertising and promotion of alcohol is effective in reducing alcohol-related harm.[45]

10.3 Supply reduction

Nationally and internationally, supply reduction is recognised as the most effective way to reduce alcohol consumption. The evidence shows that:

- Increasing price is the single most effective means of reducing consumption.[46]

- A volumetric system that would replace existing excises on alcohol with a common tax based on alcohol content across all forms of alcohol helping to reduce alcohol-related harm by increasing the relative cost of drinking higher alcohol beverages and making lower alcohol beverages more affordable and attractive[47] is supported by many Australian public health organisations, the National Preventative Health Taskforce[48] and the Henry Tax Review.[49]

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[43] Aboriginal Medical Services Alliance Northern Territory, *Options for Alcohol Control in the Northern Territory* (2008), 2.

[44] D Collins and H Lapsley, The avoidable costs of alcohol abuse in Australia and the potential benefits of effective policies to reduce the social costs of alcohol (2008), 19.

[45] D Collins and H Lapsley, The avoidable costs of alcohol abuse in Australia and the potential benefits of effective policies to reduce the social costs of alcohol (2008); National Drug Research Institute, Restrictions on the Sale and Supply of Alcohol: Evidence and Outcomes (2007).

[46] Babor et all, *Alcohol: no ordinary commodity* (2010); Shibuya et al, 'WHO Framework Convention on Tobacco Control: development of an evidence based global public health treaty' (2003) *British Medical Journal* 327, 154-7.

[47] It would be possible to tax alcohol products differently on the basis of the harm caused by these products, and thereby reduce social harms. However, this would demand that harmful products could be clearly identified and the net gains from raising taxes on it identified. This is easier said than done, and the Henry tax review considered that a volumetric system has the benefit of reducing complexity and inefficiency. It is worth noting that the introduction of a volumetric system could see a reduction in the price of some alcoholic beverages that are known to cause more social harms than other forms of alcohol (alcopops, for example). It was in recognition of this problem that the National Preventative Health Taskforce recommended a 'tiered' volumetric system that would provide 'disincentives for the production and consumption of the highest risk alcohol products'. National Preventative Health Taskforce, *Australia: the healthiest country by 2020*, Commonwealth of Australia (2009), 255.

[48] National Preventative Health Taskforce, *Australia: the healthiest country by 2020*, Commonwealth of Australia, Canberra, 2009, pp. 253–256.

[49] Australia's Future Tax System Review, *Australia's future tax system: report to the Treasurer, part two – detailed analysis*, Commonwealth of Australia, Canberra, 2010, pp. 431–443.

- Licensing restrictions that have been shown to reduce alcohol misuse and alcohol-related harm include limiting the density of alcohol outlets, restricting sale of alcohol hours, capping take-away sales and confining the types of alcohol sold.
- While Responsible Servicing of Alcohol provisions exist across Australia there is some level of concern that such are not being actively or sufficiently enforced.
- International approaches such as 'Dram Shop Liability' laws in the United States of America where any licensee or a member of their staff which irresponsibly serves a customer to the point of intoxication and commits an offence may also be charged and prosecuted for serving that person too much alcohol, or recently passed laws in New Zealand which impose significant financial penalties on licensees if intoxicated individuals are found on their premises, may provide some lessons for Australia.

The following case study is an example of how community controlled initiatives and supply restrictions can combine to create an effective strategy for the reduction of alcohol misuse and related harm:

CASE STUDY – FITZROY CROSSING

Fitzroy Crossing is a stand-out example of community participation and empowerment, where community members and their organisations have been taking a strong stance against alcohol. The women in Fitzroy Crossing decided that 'enough is enough' and decided to approach the Western Australian Director of Licensing to seek changes. Before restrictions were in place, in 2006, Fitzroy Crossing had very high rates of alcohol-related domestic violence, injuries, car accidents and illness, with fifty deaths in fifty-two weeks, including thirteen suicides (in thirteen months). It was a community in crisis. The licensing restrictions in Fitzroy Crossing now limit take-away alcohol sales to low-strength (maximum 2.7% alcohol by volume) products. Since these restrictions, there has been a huge reduction in alcohol-related harm and an increase in social benefits in Fitzroy Crossing, including:

1) a 45 percent reduction in alcohol-related hospital admissions;
2) a 27 percent reduction in alcohol-fuelled violence;
3) a 14 percent increase in school attendance; and
4) an 88 percent reduction in take-away alcohol sales.

10.4 Harm reduction/minimisation

Many of the strategies described above have been proven to contribute towards harm reduction and minimisation, primarily by reducing consumption. However, research also points to a range of additional strategies which can be employed to reduce or minimise harm in the event that alcohol misuse continues to occur, including:

- Sobering up centres and community patrols which play a vital role in keeping people out of police custody, reducing alcohol-related harm, offering practical care in a safe environment for a short time and providing 'breathing room' for family and friends.

These also provide opportunities for brief interventions by alcohol workers and other support services.

- While sobering up centres do exist in some locations around Australia, they often suffer from under-resourcing which means they frequently have few beds available and are not always in operation every night of the week.

RECOMMENDATION 5

That Australian Governments implement an evidence based, nationally coordinated and resourced approach to addressing harmful alcohol use and alcohol-related harm that reflects the National Drug Strategy 2010-2015 and the views of relevant experts such as the National Indigenous Drug and Alcohol Committee.

11. Alcohol misuse, alcohol-related harm and the justice system

Alcohol abuse is both a cause and consequence of major public health issues. In our experience, the criminal justice system is an inappropriate, ineffective and harmful way to address issues of alcohol misuse and related harm. Current criminal justice approaches, such as the criminalisation of public drunkenness, the imposition of other alcohol related offences and a lack of diversion to treatment options are not effective ways to address the causes of alcohol abuse and often exacerbate the underlying issues. They result in the criminalisation of a major public health issue and contribute to the over-incarceration of Aboriginal and Torres Strait Islander people. This fact was recognised over 20 years ago by the Royal Commission into Aboriginal Deaths in Custody.

Alcohol abuse must be viewed in the context of public health, as a social and medical issue, rather than as a criminal offence. Criminalisation does nothing to address alcoholism and the police and courts are ill-equipped to tackle such complex social and health issues. One only needs to look at the evidence included above as to what strategies have been proven to reduce alcohol misuse and related harm to see that criminalisation is not one of them.

11.1 Criminalisation of public drunkenness

It is well recognised that the criminalisation of public drunkenness has a disproportionate impact upon Aboriginal and Torres Strait Islander communities. This is a fact that was stressed by the Royal Commission into Aboriginal Deaths in Custody, leading the Commission to recommend the decriminalisation of public drunkenness.[50] For a range of reasons, Aboriginal and Torres Strait Islander peoples use public space as 'cultural space' more often than do non-Aboriginal and Torres Strait Islander peoples. Additionally, homelessness and low income levels both contribute to Aboriginal and Torres Strait Islander peoples being highly visible to police. This combined with higher level of alcohol misuse as evidenced at the beginning of this submission, result in Aboriginal and Torres Strait Islander peoples being disproportionately impacted by public drunkenness legislation which then

[50] Royal Commission into Aboriginal Deaths in Custody, National Report (1991), Recommendations 79-87.

contributes to the well recognised disproportionate rates of contact with the criminal justice system.

The decriminalisation of public drunkenness should be accompanied by the greater provision of sobering up centres as discussed above to provide for the safe care of publicly intoxicated people where necessary.

11.2 Alcohol related offences

Across Australia a number of alcohol related offences have been created which further criminalise alcohol use. Alcohol protection orders, offences for absconding from mandatory treatment, supplying alcohol to a person on a banned order, and offences for possessing or supplying alcohol in dry communities with blanket bans all serve to further criminalise alcohol use. These laws are capturing some people who otherwise would not come into contact with the criminal justice system. In particular, young people and older people are ending up with a criminal record for behaviour (possessing or drinking alcohol) which is legal elsewhere. This not only impacts upon a person's dignity, but also their prospects of gaining employment. As evidenced above, alcohol misuse has strong social and economic determinants. It is a health issue and should not be treated as being under the jurisdiction of the criminal justice system. Criminalisation is ineffective in dealing with the underlying issues of alcohol misuse and dependence. It is also a waste of public resources. Furthermore, it actually causes additional harm as it serves to further disadvantage and marginalise people and bring them into contact with the criminal justice system unnecessarily. In the context of Aboriginal and Torres Strait Islander peoples, this is particularly concerning given the extremely high and disproportionate rates of Aboriginal and Torres Strait Islander incarceration rates.

The draconian and ill-conceived nature of some of these approaches can perhaps be best exemplified by a new initiative introduced across the Northern Territory, called Alcohol Protection Orders:

CASE STUDY: ALCOHOL PROTECTION ORDERS

Despite widespread criticism from legal and health organisations, in late 2013, the Northern Territory Government introduced tough new alcohol protection orders to try to reduce crime across the Territory. The orders were introduced under the arguments that they would support the government's target of a 10 per cent reduction in crime and further strengthen the tools available to NT Police in responding to alcohol-related offences, including domestic violence.

An Alcohol Protection Order (APO) prevents a person from possessing or consuming alcohol or attending licensed premises, other than for work or for place of residence. It can be issued to any person who is charged with an offence carrying a minimum penalty of six months imprisonment or more, where alcohol was a factor (including offences under the Traffic Act). These orders can be issued for three, six or 12 months - three months for the first offence, six months for a second offence and 12 months for a third or subsequent offence. A breach of an APO by possessing or consuming alcohol, or going into licensed premises is a criminal offence carrying up to 3 months jail.

The introduction of APOs:

- Ignores what health experts say about alcoholism. An alcoholic will not stop drinking because they are placed on an APO: all it will do is send more people to jail.

- Gives Police far-reaching powers usually reserved for courts. Police will be able to ban people from drinking if they have charged them with an offence involving alcohol.

- Covers not just serious offences, but almost all criminal offending. Qualifying offences include loitering, disorderly behaviour in a public place, or high and medium range drink driving.

- Applies where a police officer believes the person was 'affected by alcohol' at the time of the alleged offence. 'Affected by alcohol' sets a very low threshold – is a person who has had a few drinks 'affected by alcohol'?

- Allows a police officer who reasonable believes that an adult is subject to an APO to search the person without warrant. This is an unacceptably broad power.

- The process for reconsideration and review of decisions to make an APO are inadequate. The 3 day timeframe to make an application for is far too short, particularly given that the application must be made in writing.

- Will have unintended consequences - An APO prohibits a person from possessing or consuming alcohol, or from entering or being in licensed premises. Many local supermarkets in the Northern Territory are licensed premises because they sell take-away alcohol. In some cases, the Bill means that those subject to orders will not be able to go to their local supermarket to do their shopping. The Government has said that they "do not care" if that's the consequence for a person having an order against them. [51]

There is no evidence to back up the Northern Territory's claims that APOs will achieve their intended effect of reducing crime. In fact, while the Northern Territory Attorney-General, Mr John Elferink said he expects the orders will result in less anti-social behaviour he also said:

> "Will this make crime go away?" he asked.
>
> "No, not necessarily.
>
> "But governments in the Territory and across the world have always struggled with alcohol and we are not above trying something novel to deal with those issues."[52]

Such a cavalier approach towards the effectiveness of a measure which has the power to fundamentally impact on an individual's liberty and which can send them to jail for up to 3 months for breaches is alarming. Rather than trialling 'novel' approaches with a 'try and see' mentality, governments should be utilising the wealth of evidence that is available as to what will be effective.

11.3 Diversion to treatment

It is well recognised that a significant amount of offending behaviour is related to drug and alcohol misuse. If we could be more successful in treating people's drug and alcohol misuse, we would also have a greater impact on reducing drug and alcohol related offending. Rather than sending people to jail, we should be diverting them to treatment services to deal with the underlying offences of their offending. In various States and Territories there are a range of programs aimed at diverting both young people and adults who have committed alcohol related offences towards treatment or including treatment as part of the sentencing

[51] See http://www.naaja.org.au/ .
[52] See http://www.abc.net.au/news/2013-12-26/alcohol-protection-orders-first-week-numbers-issued-john-elferi/5175646

process. As a result of eligibility criteria, including common exclusions for violent offences, and a lack of such programs in regional and remote areas, Aboriginal and Torres Strait Islander peoples generally have less access to such diversion programs than non-Aboriginal and Torres Strait Islander peoples. Given the high incarceration rate of Aboriginal and Torres Strait Islander peoples, and the rate of alcohol misuse, the expansion of such diversion programs have the potential to reduce the number of Aboriginal and Torres Strait Islander people in detention.

11.4 The impact of FASD

Analysis as to the number of offenders in Australia with FASD is not available. International research however, indicates that individuals with FASD have high rates of contact with the criminal justice system.[53] The criminal justice system needs to take the effects of FASD into greater consideration. People with FASD often have poor memory and can be highly suggestible, meaning they may be less reliable as witnesses or be disadvantaged or provide inaccurate information during police questioning.[54] Also, the degree to which someone is affected by FASD may raise questions as to their diminished responsibility.

Furthermore, without a formal medical diagnosis of FASD, it is difficult for magistrates to rely upon impaired functioning as a mitigating factor in sentencing. Moreover, the lack of specific management services and access to community services that may assist an individual with FASD, inhibits the ability of magistrates to effectively deal with offenders with FASD who are before the courts. Consequently, significant factors contributing to offending behaviour are not dealt with and offenders with FASD are subject to the same sentences and punishments as fully functioning offenders, despite this being inappropriate. There needs to be better resourcing of the criminal justice system to enable any person suspected of having developmental or cognitive impairments to be assessed and have access to appropriate case management that informs their treatment before the Court.[55]

The following case study provided by Aboriginal Peak Organisations Northern Territory to the Commonwealth Inquiry into Foetal Alcohol Spectrum Disorder, demonstrates the inappropriateness of the current situation as recognised by the Court.

Case Study:

A 22 year old Aboriginal female who resided in Alice Springs had been diagnosed with Foetal Alcohol Syndrome. Despite this, the female has had repeated contact with the criminal justice system since 2008 and consequently experienced many periods of imprisonment. A Magistrate in Alice Springs commented on the inappropriateness of imprisoning the woman but noted the dearth of alternate options: "*The Northern Territory Government has chosen not to provide any services for people such as [X] ... The Northern Territory Government is well aware that there are people such as [X] in this community who need assistance, and they have chosen, at an executive level, to make a decision not to provide those services....I*

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[53] Streissguth et al 'Risk factors for adverse life outcomes in fetal alcohol syndrome and fetal alcohol effects' (2004) *Journal of Developmental and Behavioral Pediatrics* 25(4): 228–238; Cox, L.V., Clairmont, D. and Cox, S. ' Knowledge and attitudes of criminal justice professionals in relation to fetal alcohol spectrum disorder (2008) *Canadian Journal of Clinical Pharmacology* 15(2): e306–e313.

[54] Roach, K. and Bailey, A., 'The relevance of fetal alcohol spectrum disorder and the criminal law from investigation to sentencing' (2009 *University of British Columbia Law Review* 42(1): 1–68; See *Western Australia v Cox* [2008] WASC 287 per Martin C.J. at [1]–[8].

[55] Aboriginal Peak Organisations Northern Territory, *Submission to the Australian House of Representatives Standing Committee on Social Policy and Legal Affairs Inquiry into Foetal Alcohol Spectrum Disorder* (2011), 20.

expect they're saying that the criminal justice system should be picking up and dealing with people who suffer as she suffers from an illness. In my opinion that's highly inappropriate ... There are ... few sentencing options available to this court ... There is nothing to be gained from giving consideration to specific deterrence, there is very little gained in giving consideration to ... rehabilitation." The female was sentenced to a period of imprisonment.[56]

The need for improved availability of and access to appropriate community care and support services is evident. Opportunities must be offered to divert people with FASD away from the criminal justice system and away from incarceration.

RECOMMENDATION 6

That all Australian Governments recognise in legislation, policy and practice the principle that alcohol misuse and alcohol-related harm is a public health issue and that criminal justice approaches are an inappropriate, ineffective and harmful means of addressing such.

RECOMMENDATION 7

That public drunkenness is decriminalised in all Australian jurisdictions and that such is accompanied by increased investment in the provision of appropriate services, including sobering up centres and training of police and health care staff.

RECOMMENDATION 8

That criminal offences related to the possession or use of alcohol, or absconding from an alcohol treatment program, be removed.

RECOMMENDATION 9

That diversionary treatment programs for alcohol related offending, which are culturally competent for Aboriginal and Torres Strait Islander peoples, inclusive of family members and community supports, are expanded and provided in regional and remote areas in recognition of the fact that addressing an individual's alcohol misuse and dependence issues is a more effective means of rehabilitation.

RECOMMENDATION 10

That the criminal justice system develop better screening processes in order to identify and assess people affected by Foetal Alcohol Spectrum Disorder so that such can inform their treatment before the courts.

[56] Aboriginal Peak Organisations Northern Territory, *Submission to the Australian House of Representatives Standing Committee on Social Policy and Legal Affairs Inquiry into Foetal Alcohol Spectrum Disorder* (2011), 20-21.

RECOMMENDATION 11

That increased investment is made in appropriate community support services so that people with disability, cognitive impairment and mental illness, including Foetal Alcohol Spectrum Disorder, can be appropriately diverted away from the criminal justice system.

12. Conclusion

Alcohol misuse and related harm and its social and economic costs is a significant problem in Australia, not only in relation to Aboriginal and Torres Strait Islander communities, but in relation to the wider community in general. A significant degree of consensus already exists amongst the relevant experts in regards to the most effective way forward. We need a nationally coordinated strategy that addresses the multi-faceted social and economic determinants underlying the issue and reflects the need for strategies that address demand, supply and harm minimisation.

For strategies to work in Aboriginal and Torres Strait Islander communities, they must be locally driven and community controlled. They need to be appropriately resourced, on an ongoing basis that is protected from election-cycle politics.

Current criminal justice approaches, are not effective ways to address the causes of alcohol abuse and often exacerbate the underlying issues. They result in the criminalisation of a major public health issue and distract us from developing and introducing strategies which work.

The evidence demonstrates that the primary method by which we can address alcohol misuse and related harm is through a public health framework. Aboriginal and Torres Strait Islander communities must have access to quality health care services, programs and facilities that are culturally appropriate and designed and delivered with the involvement of those communities themselves. Particularly given the significant gap in health outcomes for Aboriginal and Torres Strait Islander peoples, it is essential that appropriate and effective laws, policies and programs are developed that ensure access on an equal basis and promote health equality for Aboriginal and Torres Strait Islander peoples.