



17 April 2014

Committee Secretary
House of Representatives Standing Committee on Indigenous Affairs
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Parliament House
Canberra ACT 2600

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RE: Submission Response – Inquiry into the harmful use of alcohol in Aboriginal and Torres Strait Islander communities

Attached is the Aboriginal Health Council of Western Australia's (AHCWA) Submission Response on the Inquiry into the harmful use of alcohol in Aboriginal and Torres Strait Islander communities.

AHCWA welcomes the opportunity to both receive and provide additional feedback on its submission.

Yours sincerely

Des Martin
Chief Executive Officer
Aboriginal Health Council of Western Australia

Aboriginal Health Council of Western Australia Submission Response

Inquiry into the harmful use of alcohol in Aboriginal and
Torres Strait Islander communities



AHCWA

**Aboriginal Health Council
of Western Australia**

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Acknowledgement(s)

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Acronyms

ABS	Australian Bureau of Statistics
ACCHO	Aboriginal Community Controlled Health Organisation(s)
AHCWA	Aboriginal Health Council of Western Australia
AMP	Alcohol Management Plan
DAO	Drug and Alcohol Office (of Western Australia)
DoHA	Department of Health and Ageing (Commonwealth)
ED	Emergency Department
FAS	Foetal Alcohol Spectrum
FASD	Foetal Alcohol Spectrum Disorder
NACCHO	National Aboriginal Community Controlled Health Organisation
NCCAHA	National Collaborating Centre for Aboriginal Health
NDIS	National Disability Insurance Scheme
NHMRC	National Health and Medical Research Council
NIDAC	National Indigenous Drug and Alcohol Committee
OVAHS	Ord Valley Aboriginal Health Service
RTD	Ready to Drink
SCSPLA	Standing Committee of Social Policy and Legal Affairs
WHO	World Health Organization [sic]



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Submission Response

Inquiry into the harmful use of alcohol in Aboriginal and Torres Strait Islander communities

14 April 2014

*****Please note the term Aboriginal will be used to represent both terms: Torres Strait Islander and Indigenous, unless stated in a title.***

Executive Summary

Alcohol consumption in Aboriginal communities is at epidemic rates, which are perpetuated in a vicious cycle of poverty leading to a lack of access to health facilities and justice. The social determinants of harmful alcohol lead to poverty in Aboriginal communities as a dependence on alcohol begins. It has been shown that people who live in poverty are more prone to engage in harmful substance abuse, which leads to increased personal harm.

The personal harm that ensues after harmful alcohol use contributes to more hospitalisations and more suicides amongst Aboriginal men than non-Aboriginal men. Aboriginal women are also engaged in harmful drinking and the impacts of hospitalisation and suicides also affect Aboriginal women but not at the rate of Aboriginal men. 28% of suicides between 2000-2004 were the result of alcohol consumption in Aboriginal communities.

In some communities Aboriginal women are more prone to over-excessive domestic violence, rapes and deaths due to Aboriginal males consuming alcohol at harmful rates. There is also a theme of Aboriginal men who are being taken to court as a result of raping, being violent towards or killing Aboriginal women with the excuse of traditional lore and culture. The courts are allowing these excuses to be accepted but are not addressing the issue of alcohol as most of the Aboriginal men who have violently attacked these women are under the influence of alcohol. Although, this is not a national problem – it is a problem nonetheless which needs to be addressed to ensure intergenerational social determinants affecting women and children are decreased to encourage positive social, emotional and cultural wellbeing.



Dry communities and alcohol management plans need to be a collaboration effort instead of the government imposing laws onto Aboriginal communities. It has been noted that in Fitzroy Crossing where success from a Dry Community has increased is due to community support and recognition. Whereas, in Aurukun and Palm Island where alcohol management plans were imposed were not well received as there was no community consultation or substantial engagement.

FASD is currently being recognised in the health field but there is little to no information pertaining to this as a disability. The Australian government do not recognise FASD as a disability due to FASD not meeting the national criteria of a disability. Prevention Programs such as those in the Ord Valley Aboriginal Health Service are making extensive improvements in the communities with community and public education and awareness. Thus, Ord Valley has been nationally recognised as an effective, relevant and culturally appropriate FASD prevention program.

Recommendations

AHCWA recommends the following:

- Social determinants in Aboriginal communities be recognised and acknowledged as gateways for harmful alcohol consumption;
- Poverty in Aboriginal communities need to be addressed as a key priority – not only to include Aboriginal people in national economy but to discourage substance abuse and dependence;
- Education and awareness of alcohol needs to be supported and encouraged more with funding being directed to the ACCHO Sector to ensure training and skilled staff are available;
- Aboriginal women need to be acknowledged as cultural and traditional people in the legal system;
- Dry communities and alcohol management plans need to be endorsed by the community and have a collaborative approach with the government;
- FASD needs to be classified as a disability.

1 INTRODUCTION

1.1 Aboriginal Health Council of Western Australia



The Aboriginal Health Council of Western Australia (AHCWA) is the peak body for Aboriginal health in Western Australia with 20 Aboriginal Community Controlled Health Services (ACCHOs) currently engaged as members. AHCWA's mission statement provides a distinct description of its purpose, as such:

"The Aboriginal Health Council of Western Australia exists to:

Lead the development of Aboriginal health policy, influence and monitor performance across the health sector, advocate for and support community development and capacity building in Aboriginal communities, support the continued development of Aboriginal Community Controlled Health Services and build the workforce capacity to improve the health, social and emotional wellbeing of Aboriginal people in Western Australia" (AHCWA).

Central to AHCWA's core functions is its representation and advocacy of Aboriginal communities and its 20 member services; with the ability to influence policy and provide state and national level representation. AHCWA is an affiliate of the National Aboriginal Community Controlled Health Organisation (NACCHO), as such; AHCWA positively aligns with NACCHO's core values and emphasises its relationship with NACCHO in providing Aboriginal people with the best primary health care possible.

In providing high quality access to Aboriginal primary health care, AHCWA is underpinned by Article 24 of the *International Declaration on the Rights of Indigenous Peoples* (Assembly, 2008) and Article 12 of the *International Covenant on Economic, Social and Cultural Rights* (Assembly, International Covenant on Economic, Social and Cultural Rights, 1966), whereas both express the right of Aboriginal people "to have access to the highest attainable standard of physical and mental health". Accordingly, AHCWA and its member services are representative of the Western Australian Aboriginal population and their rights to access and use primary health care free of discrimination.

1.2 Rationale

AHCWA has identified key points for discussion and review in relation to the recently proposed Commonwealth inquiry into harmful use of alcohol in Aboriginal communities. The guiding principles presented by the Standing Committee on Indigenous Affairs (Committee) provide a platform for AHCWA to offer recommendations regarding alcohol use in Aboriginal communities. The guiding principles have the potential to impinge on Aboriginal peoples' access and consumption within the Australian health framework. Thus, AHCWA will submit its policy response based upon the Committee's guiding principles as follows:

- Patterns of supply of, and demand for alcohol in different Aboriginal and Torres Strait Islander communities, age groups and genders;
- The social and economic determinants of harmful alcohol use across Aboriginal and Torres Strait Islander communities;
- Trends and prevalence of alcohol related harm, including alcohol-fuelled violence and impacts on newborns, e.g. Foetal Alcohol Syndrome and Foetal Alcohol Spectrum Disorders being declared disabilities;
- Best practice treatments and support for minimising alcohol misuse and alcohol-related harm;
- Best practice strategies to minimise alcohol misuse and alcohol-related harm; and
- Best practice identification to include international and domestic comparisons.

The Committee's guiding principles provide the underpinning of this policy response and further allow AHCWA to investigate the following:

- An historical context of alcohol use in Aboriginal communities; and
- Australia's social image and culture of alcohol.

Due to the aforementioned points, the rationale for this policy response is to address the key points identified by the Committee and AHCWA that both directly and indirectly affect Aboriginal communities and the provisions of community services.

1.3 Introduction

Australia's discourse on alcohol centres around the historical context which has seen Australia encourage the patronage of alcohol as a tool of social inclusion. It should be noted that social inclusion [in regards to alcohol consumption] is subjected to those who fit within a particular societal classification. This concept is distorted in the sense that the majority of non-Aboriginal people (i.e. classical perception of 'white' Australia) are the target group who use alcohol as a tool of social inclusion and marketing. In contrast, Aboriginal people are socially excluded for their alcohol consumption, which demonstrates societal classification based on racial perceptions. Aboriginal people have not had the same encouragement to consume alcohol to fit into society due to over-excessive consumption, violence and anti-social behaviour and/or attitudes when intoxicated. This anti-social behaviour assumption of Aboriginal people when influenced by alcohol is not new but has been prominent in Australia's social imagery and consciousness since colonisation.

1.4 Historical context of alcohol use in Aboriginal communities

Historically, alcohol has been influential in determining relationships, societal hierarchies and social and economic determinants. Langton (1993) asserted that the colonial relationship to alcohol was based on creating a commodity founded on a supply and demand market, which ensured a pivotal social imbalance between Aboriginal people and settlers. With an early attempt to celebrate the landing of the First Fleet, a 'special' ration of rum was given to convicts with disastrous results that were described as licentiousness (Freeland, 1966). Consequently, alcohol was then used as a measure of control instead of a luxury, which seen the officers of the military garrison use alcohol as a means of 'commercial life' – thus the 'Rum Corps' were established and alcohol signified power (Midford, 2005). The social impact of alcohol signifying power was disastrous for Aboriginal people who did not have access to alcohol – unless the Rum Corps allowed it. Unfortunately, by this time Aboriginal people were experiencing the detriments of alcohol dependence, alcohol-fuelled violence, and cultural and identity loss and this was further espoused by settlers (including the Rum Corps). Thus, alcohol was used to occupy Aboriginal people in exchange for sexual favours, payment for labour and to instigate fighting as street entertainment (Langton, 1993). Wilson (et.al, 2005, p.7) further stated,

"Australians had some exposure to alcohol prior to European contact. However, following the arrival of the 'First Fleet' the volume and availability of alcoholic beverages increased significantly...[Alcohol] became the cornerstone of early social and economic colonial life in Australia...Aboriginals acquired a taste for alcohol, thus suited European colonists who reportedly used alcohol as a means of exchange for sex or labour with Aborigines...It was not long before the harmful effects of alcohol on the lives of Aborigines became apparent. As a response to the devastating effects of colonialism, including dispossession, and illness and death resulting from disease and confrontation, alcohol became somewhat of a panacea for Aboriginal people's pain, with many using it as a means of escape and solace".

The introduction of alcohol in Aboriginal communities was used as a controlled commodity, which was further regulated with laws prohibiting the sale of alcohol to, or purchase of alcohol by Aboriginal peoples (Wilson et.al, 2005, p.7). Prohibition of alcohol for Aboriginal people came into effect in New South Wales in 1838 and was later reflected in the other states and territories by 1929 (Wilson et.al, 2005, p.7). The prohibitions were not without exemption but were costly on Aboriginal people who were already suffering the impacts of colonisation. Accordingly, exemptions were given to those who were able to prove their ability to efficiently assimilate into the non-Aboriginal society, which meant denying and/or rejecting 'their Aboriginal identity and social relationships' (Beckett & Reay, 1964). Non-Aboriginal people were able to make considerable profits from sly-grogging during the regulations; consequently, creating another supply and demand market with Aboriginal people being the target market with similar intergenerational results from the Rum Corps days of marketing.

1.5 Western Australian Alcohol History

Western Australia history exemplifies the restrictions that Aboriginal people were subjected to and the counter-measures that the Western Australian parliament enacted. The following timeline is succinct to ensure key points in Western Australian history are identified in relation to Aboriginal peoples' connection with alcohol is brought to attention (WA Now and Then, 2013):

- 1880 *Wines, Beer and Spirit Sale Act 1880* prohibited a person from selling or supplying alcohol to Aboriginal people. This Act also prevented Aboriginal people from entering or loitering in or around licensed premises
- 1830 First liquor licenses were issued in Western Australia
Legislative Council established
- 1832 Civil and Criminal Courts system established
- 1836 First brewery in Western Australia is established
- 1837 Colonies begin establishing breweries
- 1839 Rottnest Island becomes location for Aboriginal prison
- 1842 *Master and Servant Act* becomes law
- 1843 *Publicans Act* embeds full ban on Aboriginal people being supplied alcohol
- 1859 Amendment of the *Summary Trial and Punishment Aborigines Act (Summary Jurisdiction Act)* allowed legal system to extend period of imprisonment for Aboriginal people to three years
- 1875 *Capital Punishment Act 1871* amended to abolish public executions, albeit Aboriginal people were exempted and were still able to be executed in public
- 1877 Aboriginal Protection Board established
- 1888 Aboriginal peoples are denied the right to hold mining licenses

- 1927 Aboriginal people were banned from entering Perth and were restricted to Boundary Roads with strict regulations imposed
- 1967 Constitutional Reform allowing Aboriginal people to be citizens
- 1969 Aboriginal people are given right to equal pay with the intent of moving them to stations instead of 'metropolitan' areas
- 1970 *Liquor Act 1970* the supply of liquor to Aboriginal peoples in proclaimed areas was forbidden
- 1972 *Aboriginal Heritage Act* gives legal protection to sacred sites

This timeline exposes the Western Australian government's attempts to restrict Aboriginal people from alcohol so much so that no less than two years after introducing breweries in the State the Aboriginal prison on Rottnest Island was established. Then again in 1843 with a full ban on Aboriginal alcohol supply the government established the Aboriginal Protection Board in 1877. Aboriginal people in Western Australia were subjected to laws that prevented them legally consuming alcohol, which was used as a commodity; and once caught was punished according to government laws and institutions. Western Australian alcohol restrictions encouraged a repetitive cycle of institutional abuse; whereas, Aboriginal people were denied consumption to an introduced and addictive substance. Once addicted, Aboriginal people were imperiled to racially motivated legislation that punished them by removing all rights and access to community and culture.

1.6 The Imagery of Alcohol in Australia

The imagery of alcohol in Australia is widespread across the country and has the same ideological representations and effects as a whole. The Australian alcohol industry rely heavily on sales and mass consumption to ensure revenue is upheld, thus the marketing and imagery of alcohol is just as important as the mass consumption.

Both *Image 1: Australian Patronage and Way of Living (Image 1)* and *Image 2: Australian Perception of Aboriginal consumption of Alcohol (Image 2)* illustrate the imagery associated with both Aboriginal and non-Aboriginal alcohol consumption. These images were taken directly from www.google.com.au with a search on 'Images of white Australian Alcohol Consumption' and 'Images of Aboriginal Australian Alcohol Consumption'. The paucity and sophistication associated with non-Aboriginal alcohol consumption is evident in *Image 1*, whereas to entice travelers and consumers to Australia; the promotion of alcohol and beauty is highly marketable. Albeit, the imagery associated with Aboriginal people

demonstrated in *Image 2* highlights the struggles that Aboriginal people face, which is further intensified with discarded cans, exposing over-consumption and a lack of sophistication as seen in *Image 1*.

Image 1: Australian Patronage and Way of Living

(Taken directly from <http://www.travelnt.com> Accessed: 4 April 2014)



Image 2: Australian Perception of Aboriginal consumption of Alcohol

(Taken directly from <http://theaustralian.com.au> Accessed: 4 April 2014)



This type of imagery and stigma that Australia has adopted to represent alcohol consumption in Aboriginal and non-Aboriginal cultures echoes past policies and procedures that sought to exclude Aboriginal people from social benefits and inclusion. Consequently, *Image 2* expresses the deep rooted racism of the supply and demand of alcohol, which is slowly killing Aboriginal communities.

2 PATTERNS OF SUPPLY & DEMAND

2.1 The Emergence of Supply & Demand

The emergence of alcohol supply and demand in Aboriginal communities stemmed from past events (refer to section 1.3.1: *Historical context of alcohol in Aboriginal communities*). These events produced an intergenerational dependence on alcohol, which more or less propagated Aboriginal communities' dependence on welfare and alcohol in order to exist. The alcoholism that is portrayed in Aboriginal communities is due to inequitable laws imposing on culture and identity (Hudson, 2011). Accordingly, the inequitable laws imposed on Aboriginal communities [including but not limited to: alcohol restrictions; the right to education, housing; the right to enter city limits; the right to equal pay; the right to stay on country; the right to citizenship] increased dependency on governments, which meant that Aboriginal people [especially in remote communities] were reliant on governments in order

to live (Hudson, 2011). The removal of Aboriginal peoples' identity and culture led to overwhelming alcohol consumption and non-economic participation, as such Hudson (2011, p.vii) stated:

"The harmful effects of excessive alcohol consumption are a problem across Australia but more pronounced in many Aboriginal communities because nearly every resident is reliant on welfare. The absence of a real economy and appropriate controls on alcohol has created social environments where welfare payments are spent on alcohol and heavy drinking has become endemic."

This reliance on alcohol is detrimental to the survival of Aboriginal culture in various communities. The impacts of alcohol and government dependency imbrues Aboriginal culture, identity, spirit and health outcomes. Consequently, national guidelines for consumption of alcohol does not address excessive consumption but encourages small amounts of alcohol daily in order to reduce excessive consumption, which is generic across the nation.

2.2 Guidelines for Alcohol Consumption to reduce excessive consumption, disease and harm

In 2009 the National Health and Medical Research Council (NHMRC) released its national guidelines for reducing the health risks associated with the consumption of alcohol. The NHMRC encouraged both men and women to maintain healthy levels of alcohol consumption, thus stating, '*...drinking no more than two standard drinks on any day reduces the lifetime risk of harm from alcohol-related disease of injury*' (ABS, 2012). As such, *Table 1: Standard Drink Equations based on 10mL of Alcohol (Table 1)* reflects what constitutes a standard drink (Government of WA Drug and Alcohol Office):

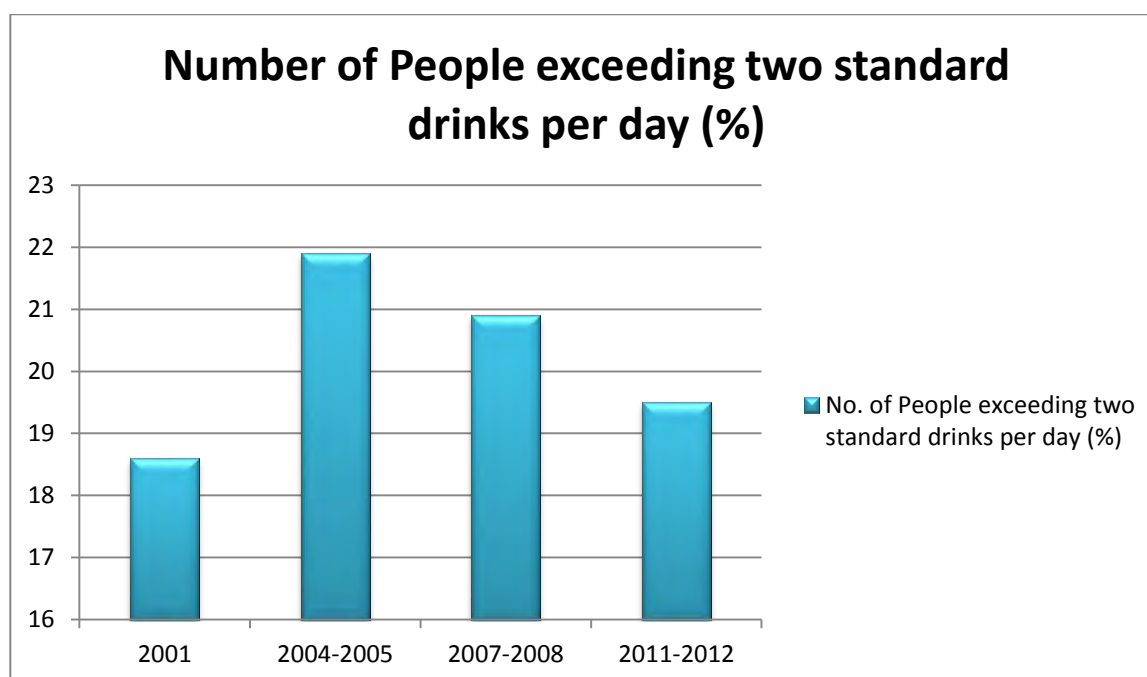
Table 1: Standard Drink Equations based on 10mL of Alcohol

Standard Drink Equations	
Standard Drink Contains 10mL of Alcohol	285mL of Full Strength Beer 425mL of Low Strength Beer 100mL of Wine (red and white) 30mL of Spirits 275mL bottle of Ready to Drink (RTD) (5% alcohol content)

The ABS (2012) further ascertained data from 2001 to 2011-2012, which focused on the number of people who exceeded the NHMRC recommended standard two drinks a day.

Chart 1: Number of People exceeding NHMRC recommended two standard drinks per day (Chart 1) reflects the number of people who exceeded two standard drinks per day:

Chart 1: Number of People exceeding NHMRC recommended two standard drinks per day



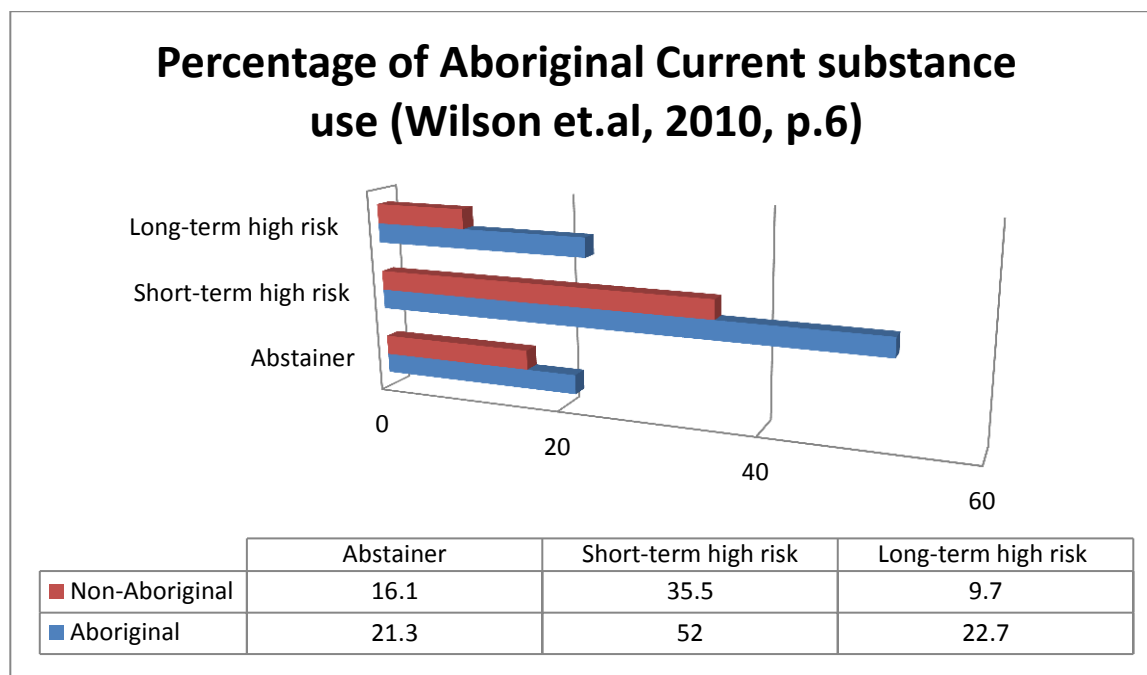
Although there was a decline in the number of people exceeding two standard drinks per day there were still 4,530,981 Australian citizens engaging in risky consumption of alcohol. The number of identified Aboriginal people who participated in the 2011 Census totaled 548,400 this is 3,982,581 of non-Aboriginal people exceeding two standard drinks per day. Grey et.al (2010) emphasised this dichotomy between Aboriginal and non-Aboriginal peoples' alcohol consumption by asserting that 20% of non-Aboriginal people drink at excessive levels which pose short-term risks. These risks are usually associated with 'heavy episodic consumption' (i.e. binge-drinking). Furthermore, non-Aboriginal people are 10% likely to drink at levels which cause long-term risks (Grey et.al, 2010). In contrast, Grey et.al (2010) suggests that Aboriginal people binge-drink at levels which double their risks of short and long-term damage than non-Aboriginal people. Binge-drinking is a national problem, yet Aboriginal people are still exposed to excessive alcohol consumption; thus leading to numerous health problems that the Aboriginal Community Controlled Health Organisation

(ACCHO) Sector is having to monitor, evaluate and control. Doctor Sharman Stone (Chair of Committee into Inquiry) stated (Karvelas , 2014):

“...while the committee was not singling out Aboriginal and Torres Strait Islander people as the group with alcohol problems, those communities were at risk. We know that Aboriginal and Torres Strait Islander people are more likely to abstain from alcohol than non-Aboriginal and Torres Strait Islander people. However, we are concerned Aboriginal and Torres Strait Islander people who do consume alcohol drink at riskier levels which has a greater impact on their health”.

Doctor Stone has presented an issue not based on discrimination but based on social and community welfare that needs addressing.

Chart 2: Percentage Comparison of Aboriginal and Non-Aboriginal Current Substance Use

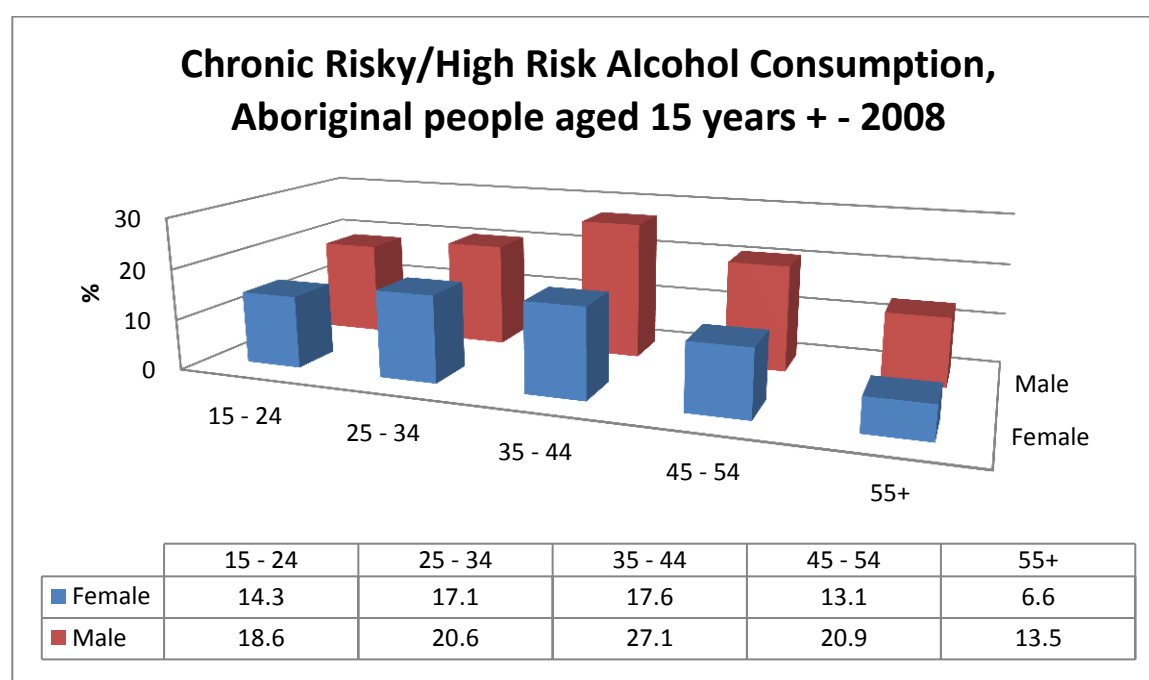


As per *Chart 2: Percentage Comparison of Aboriginal and Non-Aboriginal Current Substance Use* (Chart 2) Aboriginal people are more likely to abstain from alcohol than non-Aboriginal people, however, risky alcohol consumption clearly confirms Doctor Stone’s sentiments that the inquiry is based on social and community welfare rather than racial stereotyping. The demand and supply of alcohol in Aboriginal communities is at a higher level than non-Aboriginal communities but with national guidelines that encourage two standard drinks per day is confusing even to the whole of Australia.

2.3 Patterns of Aboriginal Alcohol Consumption Supply and Demand

The patterns of Aboriginal alcohol consumption supply and demand are overwhelming when the standard amount of alcohol is 10mL (20mL equals two standard drinks daily). The following chart illustrates the supply and demand paradigm that Aboriginal people are facing (ABS, 2010):

Chart 3: Chronic Risky/High Risk Alcohol Consumption, Aboriginal people 15 years +



The following points (ABS, 2010) provide some explanation regarding *Table 3: Chronic Risky/High Risk Alcohol Consumption, Aboriginal people aged 15 years + (Table 3)*, whereas:

- In 2008, around 1 in 6 Aboriginal people aged 15 years + (17%) drank at chronic risky/high risk levels, similar to rated reported in 2002 (15%);
- In 2008, alcohol was associated with 7% of all deaths and an estimated 6% of the total burden of disease for Aboriginal people;
- 2008, 46% were low risk drinkers and over one-third (35%) had abstained from drinking alcohol (i.e. not consumed alcohol in the last 12 months or had never consumed alcohol);
- Men are 20% compared to women 14% more likely to drink at chronic risky/high risk levels; and

- People in remote areas were more likely than those in non-remote areas to be abstainers (46% compared to 31%).

These statistics do not promote encouraging patterns of supply and demand for Aboriginal communities. The national approach to minimise harmful alcohol consumption in Aboriginal communities needs to be specific to the States and Territories. This was noticed by Senior & Richard (2008, p.76) where the pattern of supply and demand was prevalent in Western Australian communities, however; the pattern of demand was more noticeable in older men who drank in the community and encouraged 'grog runs' (grog runs will be further discussed in this submission).

3 SOCIAL AND ECONOMIC DETERMINANTS OF HARMFUL ALCOHOL USE

3.1 Socio-economic deprivation leading to excessive alcohol consumption

The World Health Organization [sic] (WHO) attained a clear link between socio-economic deprivation and risky alcohol dependence in Aboriginal communities (Wilkinson & Marmot, 2003). The link was furthered by WHO, by targeting specific reasons of socio-economic deprivation, thus the historical and continuing impact of colonisation and dispossession have led to Aboriginal people being dependent on the government and have become the product of excessive alcohol consumption (Wilkinson & Marmot, 2003). The National Indigenous Drug and Alcohol Committee (2009) (NIDAC) agreed with WHO by suggesting alcohol causes high social dysfunction and problems, which contribute negatively to employment, incarceration, health and economic participation.

Zubrick et.al (p. 86) perpetuated alcohol consumption as a distinct cause to social dysfunction leading to non-economic participation of Aboriginal people, *'Failures in community governance, on the other hand, have been associated with catastrophic social dysfunction such as endemic alcohol abuse and family violence'*. This statement infers the social determinants that are contribute to excessive alcohol consumption thus leading to welfare dependence and socio-economic deprivation.

3.2 Social determinant categorisation and Aboriginal health

The National Collaborating Centre for Aboriginal Health (NCCAHA) categorised social determinants into three categories: distal, proximal and intermediate (Reading and Wien, 2013, p. 7). These three categories provide tiers of Aboriginal community living and

promote awareness to the complexity of Aboriginal socialisation, determinants, environment and economy.

Figure 1: Aboriginal Health Social Determinant Categorisation

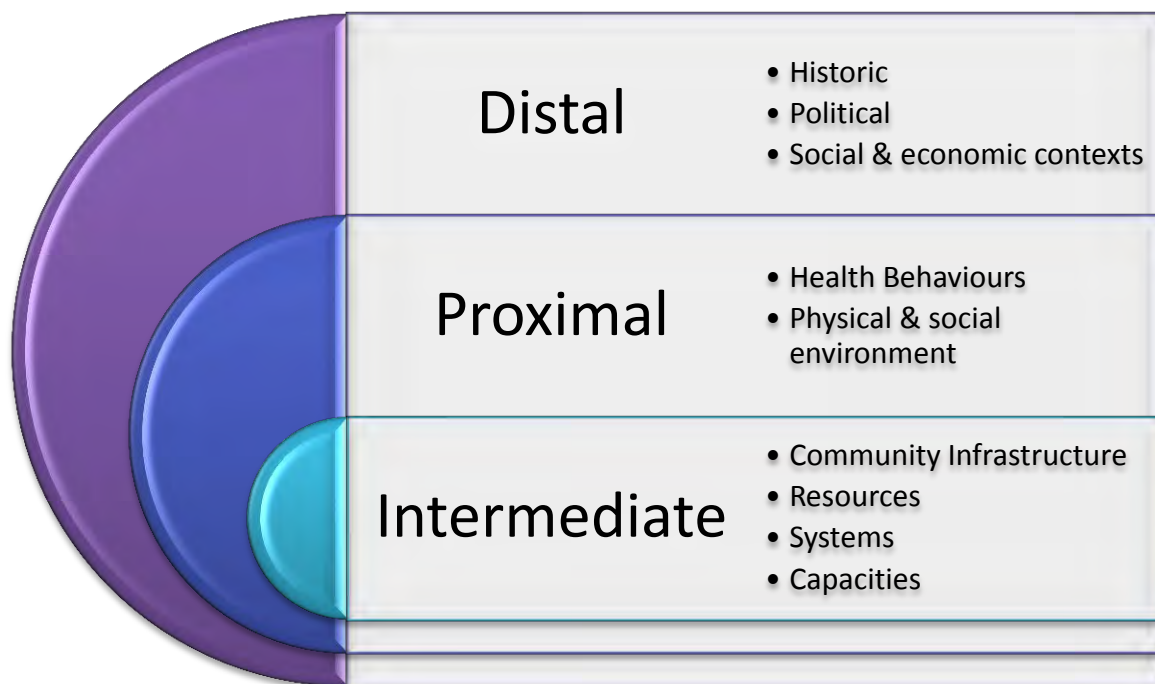


Figure 1: Aboriginal Health Social Determinant Categorisation (Figure 1) reveals a cultural and holistic approach to social determinants that is inclusive of Aboriginal history, political and community infrastructure. These categories are essential in providing the government a cultural and holistic framework to assist in the prevention of excessive alcohol consumption. Reading and Wien (2013, p. 11) commented that if distal and proximal determinants of health are not supported by funding and resources then the choice to access health is denied. Consequently, if the basics of life are not available to communities then health is denied as access and equality is distorted due to social exclusion of Aboriginal alcohol consumption.

3.3 Poverty and Alcohol Consumption

There is a strong link to social determinants and alcohol leading to or stemming from poverty. Social determinants in Aboriginal communities are relative of each other, whereas,

if health is poor then access to education and employment is hindered. Reading and Wien (2013, p.7) stated,

*“Individuals, communities and nations that experience inequalities in the social determinants of health not only carry an additional burden of health problems, but they are often restricted from access to resources that might ameliorate problems. Not only do social determinants influence diverse dimensions of health, but they also create health issues that often lead to circumstances and environments that, in turn, represent subsequent determinants of health. For instance, living in conditions of low income have been linked to increased illness and disability, which in turn represents a social determinant, which is linked to **diminished opportunities to engage** in gainful employment, **thereby aggravating poverty**”.*

Social determinants that impact on Aboriginal peoples' life courses are able to create conditions (i.e. determinants) that will affect their health (Reading & Wien, 2013). Poverty is associated with substance abuse (including but not limited to alcohol), which can potentially provoke an array of social determinants leading to stressful family environments and mental health conditions (Reading & Wien, 2013).

Kelm (1998, p.123) provided an analysis of Canada's health system, which includes numerous comparisons about socio-cultural displacement, poverty and government influence and/or enforcement with Australia. As such (Kelm, 1998, p.xviii),

“Colonisation is a process that includes geographic incursion, socio-cultural dislocation, the establishment of external political control and economic dispossession, the provision of low-level social services and ultimately, the creation of ideological formulations around race and skin colour that position the colonizer at a higher evolution level than the colonised”.

The relationship between distal determinants, poverty and alcohol consumption seem to go hand in hand. The historical context and sociology of poverty in Aboriginal communities is intergenerational and is heavily influenced by excessive alcohol consumption. Social determinants in Aboriginal communities are not singular and not able to work in isolation of each other (i.e. housing, substance abuse, health, employment and incarceration etc.). Suffice to say, social determinants needs to be addressed in a pluralist governmental style that allows Aboriginal people the ability to effectively participate in the national economy, instead of the current status of poverty.

4 ALCOHOL RELATED HARM

4.1 Snapshot Trends of Aboriginal Alcohol Related Harm

The Steering Committee for the Review of Government Service Provision (SCRGSP) provided a snapshot of Aboriginal hospitalisation rates relating to injuries resulting from assault. Accordingly, Aboriginal males are between 1.2 and 6.2 times more likely to be hospitalised for injuries resulting from assaults than non-Aboriginal males (SCRGSP, 2009). In contrast, Aboriginal females are between 1.3 and 33.0 times greater than non-Aboriginal females to be injured from an assault (SCRGSP, 2009). The alarmingly high rate of Aboriginal females being injured as a result of alcohol is relative to social and family dysfunction that was mentioned in section 3.3 *Poverty and Alcohol Consumption*. Alcohol related deaths for Aboriginal peoples is between 5 and 19 times greater than non-Aboriginal people (SCRGSP, 2009), which further adds to social and family dysfunction as 1 in 5 (22%) of Aboriginal alcohol related deaths is directly caused by an argument while intoxicated (Zubrick, et al.).

The disproportionate rates between Aboriginal and non-Aboriginal hospitalisations is overwhelming and the violence associated with alcohol is a burden that impinges Aboriginal health and under-resourced ACCHOs. Alcohol misuse contributes to social determinates yet, the ACCHO Sector is under-resourced and under-funded to provide services pertaining to alcohol related harm. As such, Wilson et.al (2010, p.4) stated,

“Alcohol misuse is a contributing factor to a wide range of health and social problems, including: violence; social disorder; family breakdown; child neglect; loss of income or diversion of income to purchase alcohol and other substances; and, high levels of imprisonment...Indigenous Australians experience harms associated with alcohol use, including deaths and hospitalisation at a rate much higher than other Australians”.

The rate of Aboriginal harm and deaths associated with alcohol misuse is at an extremely high level and there has been no real measures taken nationally or by the states and territories that have been consistent. Aboriginal communities are engaging in alcohol reform by way of requesting government intervention but even this has issues that the whole of community need to address.

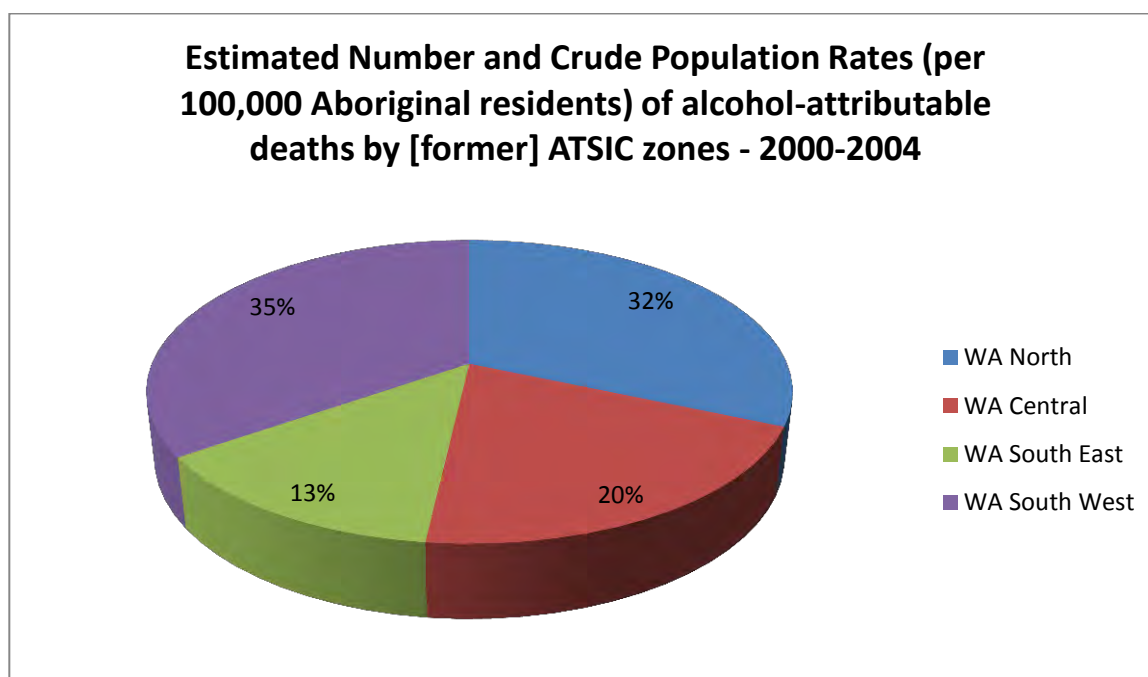
4.2 Death resulting from Alcohol Misuse

There is a substantial gap between Aboriginal and non-Aboriginal life expectancy, more notably the Aboriginal population born in 2010-2012 has an estimated life expectancy of 10.6 years lower than that of non-Aboriginal males (i.e. 69.1 years compared to 79.7) (AIHW, 2013). Accordingly, Aboriginal females in 2010-2012 are estimated at 9.5 years, which is 73.7 years compared to non-Aboriginal females reaching 83.1 years (AIHW, 2013). The life

expectancy for Aboriginal people is already at a point of disarray and with harmful alcohol use and alcohol induced conditions contributing to approximately 7% of Aboriginal deaths (Wilson et.al, 2010, p.4), the gap will continue to widen unless practical and efficient prevention programs are put in place.

In Western Australian alcohol related deaths are second to Northern Territory and this would be pursuant to the Aboriginal population – considering the Northern Territory has a higher population of Aboriginal people than Western Australia. The following chart provides an estimation of Western Australian Aboriginal alcohol-attributable deaths as per the [former] ATSIC zones from 2000-2004 (Wilson et.al, 2010, p.4):

Chart 4: Estimated Number and Crude Population Rates (per 100,000 Aboriginal residents) of alcohol-attributable deaths by [former] ATSIC zones – 2000-2004



Further to Chart 4: Estimated Number and Crude Population Rates (per 100,000 Aboriginal residents) of alcohol-attributable deaths by [former] ATSIC zones – 2000-2004 (Chart 4), the following table provides a more specific number of alcohol-attributable deaths in each state and territory (Wilson et.al, 2010, p.4):

Table 2: State and Territory Aboriginal alcohol-attributable deaths per 100,000 capita

Region	Aboriginal Deaths per 100,000 capita	Overall Percentage
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WA North	70	8.8%
WA Central	45	7.4%
WA South East	30	8.1%
WA South West	77	4.8%
QLD Far North West	73	9.2%
QLD North	107	5.5%
QLD South	58	4.2%
QLD Metro	47	2.3%
NT North	135	6.8%
NT Central	134	14.6%
NSW West	94	4.0%
NSW East	86	3.3%
NSW Metro	49	2.2%
South Australia	78	5.9%
Victoria	49	3.4%
Tasmania	7	0.8%
Torres Strait Islands	7	2.1%

These figures are disproportionate of the nations' population considering Aboriginal people make up 3% of the nation (ABS, 2010). Insofar, Aboriginal deaths relating to alcohol consumption are prevalent in communities as such the following table exhibits the top five causes of Aboriginal alcohol-attributable deaths from 1998-2004 (Wilson et.al, 2010, p.5):

Table 3: Top 5 Aboriginal deaths resulting from alcohol from 1998-2004

Aboriginal Male(s)			
Condition (from highest to lowest)	Number	Percentage	Mean Age of Death
Suicide	222	28	29
Alcohol Liver Cirrhosis	210	16	56
Road Traffic Injury	87	10	30
Assault Injury	70	7	34
Hemorrhagic Stroke	60	4	27
Total(s)	649	65	35
Aboriginal Female(s)			
Alcohol Liver Cirrhosis	136	28	51
Hemorrhagic Stroke	78	16	25
Assault injury	48	10	32
Suicide	33	7	27
Road Traffic Injury	18	4	36

Total(s)	313	65	34
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According to *Table 3: Top 5 Aboriginal deaths resulting from alcohol from 1998-2004 (Table 3)*, Aboriginal males are 48% more likely to die than Aboriginal females from alcohol consumption and/or misuse. More importantly, alcohol induced suicides have an overwhelming representation in Aboriginal males, which seems relatively high even though the figures are aggregated.

4.3 Alcohol Induced Suicides

In response to *Table 3*, Aboriginal males have a 28% alcohol induced suicide rate, which in comparison to Aboriginal females at 7% is discouraging – especially given that the median age for Aboriginal males is 29 years. Unfortunately, there is no substantive evidence into why humans commit suicide or what the tell-tale signs are. Suffice to say, if there is no evidence into why people commit suicide then there is little to no chance that logical evaluation of why alcohol induced suicide occurs or what symptoms are presented. This presents issues considering that, “...it is estimated that alcohol is associated with 40% of male and 30% of female suicides within the Indigenous Australian population” (Wilson et.al, 2010, p.5). In Fitzroy Crossing in Western Australia alcohol contributed to 13 suicides in 13 months in 2007 (Latimer, et al., 2011). Moreover, in 2006, the Kimberley toxicology reports showed high alcohol-blood levels of 19 out of 21 Aboriginal suicides (Hudson S. , 2011).

With such high rates of alcohol induced suicides amongst Aboriginal peoples the national comparison between Aboriginal and non-Aboriginal people reflects the above mentioned statement; thus the following table represents the comparison between Aboriginal and non-Aboriginal peoples and gender variances (Wilson et.al, 2010, p.5):

Table 4: Comparison between Aboriginal and Non-Aboriginal Alcohol Induced Suicides from 2000-2004

	Male(s)	Female(s)
Aboriginal	159	27
Non-Aboriginal	123	27

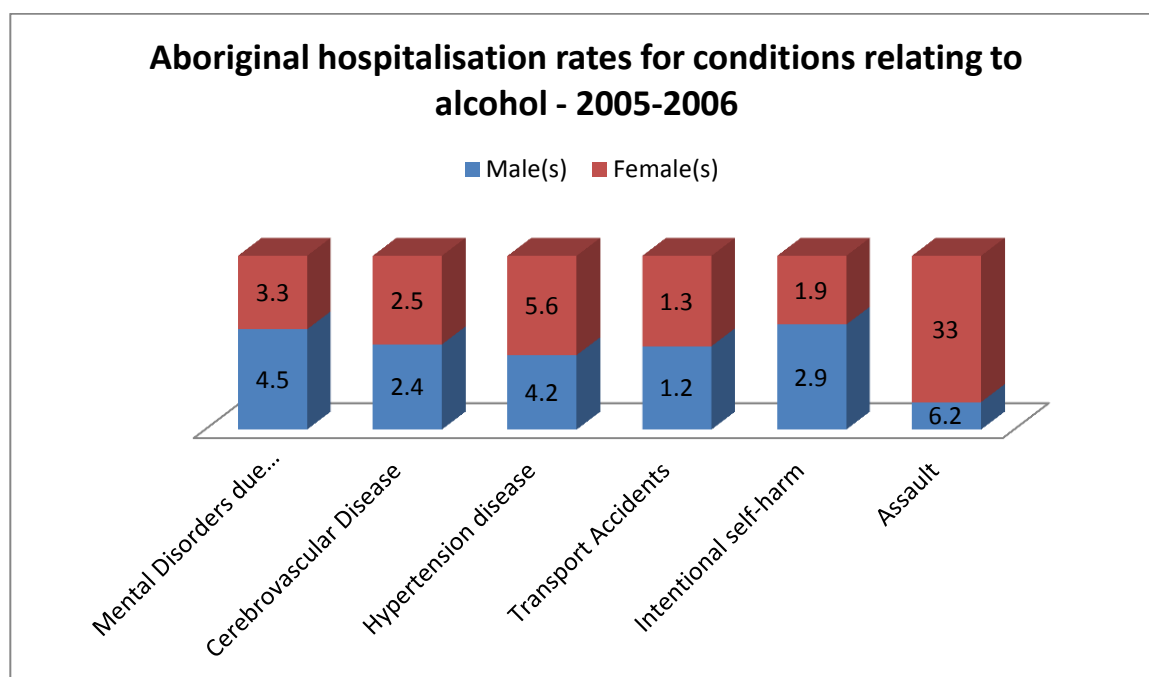
Table 4: Comparison between Aboriginal and Non-Aboriginal Alcohol Induced Suicides from 2000-2004 (Table 4) elucidates a comparison in suicides rates between Aboriginal and non-Aboriginal peoples. However, in saying this, the rates are disproportionate considering that Aboriginal people make up 3% of the national population. Considering Aboriginal people account for 3% of the national population, an estimated 5% of non-Aboriginal males (of the national population) and 1.16% of non-Aboriginal females make up the national percentage

of alcohol induced suicides. The number of non-Aboriginal people committing suicide under the influence of alcohol is almost the same as the national Aboriginal population, which does promote practical outcome based programs being offered to Aboriginal communities to assist in the prevention effectively.

4.4 Alcohol Induced Hospitalisations

In 2001, Aboriginal hospitalisations [due to alcohol] were responsible for 8,196 hospital admissions, which incurred 42,238 bed days, with the total costs amounting to over \$30 million (Government of WA Drug and Alcohol Office). Consequently, the high number of Aboriginal people being admitted to hospital due to excessive alcohol consumption is demonstrated in the following chart (Wilson et.al, 2010, p.5):

Chart 5: Aboriginal hospitalisation rates for conditions in which alcohol is a contributing factor, 2005-2006



Aboriginal social inequalities lead to burdensome hospitalisation rates, which affect not only those admitted but the families and whole of community. *Chart 5: Aboriginal hospitalisation rates for conditions in which alcohol – 2005-2006* (Chart 5) demonstrates Aboriginal health status ratios between males and females on an even par, however, the annihilating comparison of assaults against women cannot be ignored as an element of addressing harmful alcohol usage in Aboriginal communities.

5 ALCOHOL-FUELLED VIOLENCE AGAINST ABORIGINAL WOMEN

5.1 The Shocking Truth

The shocking truth is that Aboriginal women are 80 times more likely to be hospitalised for assault and injury resulting from alcohol (Sutton, 2014). Sutton (2014) describes the increasing rate of violence against Aboriginal women as ‘outrageous’ and social determinants such as unemployment, alcoholism and gambling abuse are factors which lead to the savage alcohol-fuelled violence that Aboriginal women face. In one case Sutton (2014) described the violence that Aboriginal women suffer as a result of alcohol as:

“...the case of the man who used a hose to whip his 32-year-old wife, stomping on her abdomen and dragging her naked body over rough ground, before raping her, and then bashing her with either a stick or metal pole, causing severe internal injuries, before finishing her off with a rock”.

Dr Howard Bath [the Northern Territory’s Children’s Commissioner] confirmed recent statistics of the Northern Territories’ five major hospitals, which showed in 2010 that (Sutton, 2014):

- Non-Aboriginal females hospitalised for assault was 0.3 for every 1000 women in the population; and
- Aboriginal females hospitalised for assault was 24.1 for every 1000 women.

Accordingly, these figures resulted in 27 non-Aboriginal females compared to 842 Aboriginal females being hospitalised due to alcohol-fuelled violence (Sutton, 2014). Dr Bath went further to comment that, ‘*Alcohol is the worst factor by a country mile...Between 60 and 70 per cent of violence is directly related to alcohol*’ (Sutton, 2014).

Sutton (2014) further commented that Aboriginal men and to a lesser extent Aboriginal women and non-Aboriginal men were responsible for Aboriginal women being attacked and hospitalised. The shocking truth is that alcohol-fuelled violence against women is ignored, while violence against women in other countries such as India is being identified as a breach of human rights in Australia (Sutton, 2014).

The shocking truth of alcohol-fuelled violence against Aboriginal women needs to be addressed as the intergenerational effects on the children of these women only develop a vicious cycle of alcohol and abuse.

5.2 Alcohol-fuelled Violence against Aboriginal Women is Cultural Extermination

The non-Aboriginal perception of Aboriginal family violence is to turn a blind eye and continue with your daily norms. This is also a concern in Aboriginal communities as Aboriginal families are turning away as alcohol-fuelled family violence has become the norm. Even though, alcohol-fuelled family violence has become the 'norm' in Aboriginal communities; it does not mean that it is cultural. The normality of alcohol and violence has become regular in Aboriginal communities, whereas, *'There's a lot of alcohol, a lot of sexual assaults and a lot of really terrible violence. It's a normal thing in an Aboriginal community'* (The Australian, 2007).

It has been noted that violence and raping of Aboriginal women by Aboriginal men is a tightly structured form of ritual, ceremony and proscribed procedures as per traditional norms (The Australian, 2007). Albeit, this concept of traditional norms has been distorted through the harmful use of alcohol, where Aboriginal women are now being subjected to horrific violence due to alcohol and lust.

The cultural extermination of Aboriginal people is due to alcohol and acculturation. Alcohol as noted, was introduced and is now being used as an excuse for violence in Aboriginal communities. Thus, (The Australian, 2007) noted the excuse of customary lore and traditions is now being used as a way of controlling and manipulating both the legal system and Aboriginal women.

5.3 Australia's legal system perpetuates violence against Aboriginal Women

Aboriginal men are using cultural and traditional practices as an excuse to avoid lengthy jail sentences (The Australian, 2007). Aboriginal women who are victims of alcohol-fuelled violence and rape are also victims of the Australian legal system – especially when Aboriginal men are fallaciously claiming cultural and traditional practices as reason why Aboriginal women are 'supposed' to be abused.

The defense of cultural and traditional practice is distorted when Aboriginal men have committed acts of violence while intoxicated. The Australia (2007) stated:

“Even so, some Aboriginal men use the notion of custom and tradition to get their own way. Journalist Paul Toohey has written of how indigenous [sic] men in the NT fallaciously claimed that tribal law justified their rapping of Aboriginal girls and women. The truth is that most, if not all, of these rapes occur because of lust and alcohol, not because the girls and women have committed a traditional offence”.

The Australian legal system perpetuates alcohol-fuelled violence against Aboriginal women by giving Aboriginal men lenient sentences when using the defense of intoxication combined with cultural and traditional practices (The Australia, 2007). The concept that judges still view Aboriginal men’s treatment of Aboriginal women as distinct to how non-Aboriginal people treat each other; and that Aboriginal women do not have the same rights as non-Aboriginal women when it comes to alcohol-fuelled [or non-alcohol-fuelled] violence and rape (The Australian, 2007).

In the case of *R v GJ* [2005] NTSC 48, a 55 year old Aboriginal man used the defense of customary law against raping a 14 year old Aboriginal girl. Martin CJ [14-18] accepted that the girl had objected to having sexual intercourse but because of customary law, which promised the girl to the man, Martin CJ felt it necessary to perpetuate the cycle of rape and violence against Aboriginal females. Thus, Martin CJ expressed his acceptance of the girl’s objections but due to customary law, the girl had to real reason to object. Martin CJ [19] further perpetuated the cycle by only charging the man with unlawful sexual intercourse and not rape. Martin CJ [25] further commented that:

“The Northern Territory law says that a young child or a girl or a woman is entitled to make a free choice, and has the right to say ‘no’. They have the right to say ‘no’ to sexual intercourse, even if it is the promised husband who is demanding sexual intercourse. They have the right to say ‘no’ to promised marriages. Men in Aboriginal communities are not entitled to strike women. That includes women who are their wives or who are promised to them as their wives”.

Martin CJ’s comments [25] were useless to the young girl as she was told she has a right to say ‘no’ but will not constitute rape if it is customary. The problem with this case is that it perpetuated a culture of violence and alcohol based on a version of Aboriginal custom, culture and tradition founded on what Aboriginal men say. Thus, women will always remain the social, legal and traditional victim, which the Australian legal system endorsed in *R v GJ*. Marcia Langton spoke on behalf of Aboriginal women who are subjected to this type of alcohol-fuelled violence with, *“Are the Aboriginal legal services which supposedly work for us ever going to stop arguing that rape is traditional law”* (The Australia, 2007). Langton’s comments were further supported by Finnane DCJ, whereas, in the case of an Aboriginal man attacking and raping an Aboriginal woman, Finnane DCJ stated, *‘Aboriginality does not provide justification for [his] obsessive and cruel behaviour’* (The Australian, 2007).

Unfortunately, this type of behaviour towards Aboriginal women is intergenerational and is increased in communities where poverty is paramount. The effects that alcohol-fuelled violence and the blasé attitude from the legal system increases the violence towards Aboriginal women and children with no legal, social or economic support to assist them.

Aboriginal women have been drawing attention to communities by imploring the government to assist with excessive consumption of alcohol. Accordingly, Aboriginal women have been the primary leaders in alcohol restrictions in communities – thus enabling dry communities.

6 BEST PRACTICE TREATMENT & SUPPORT

6.1 Introducing Dry Communities in Western Australia

The impetus of introducing dry communities is usually an Aboriginal woman led initiative. In Western Australia there are two communities: Fitzroy Crossing and Halls Creek, which have been successful in enforcing the responsible service of alcohol (Hudson S. , 2011). Furthermore, both Fitzroy Crossing and Halls Creek have noticed a gradual decline in the number of alcohol-related crimes and hospital admissions ranging between 20% and 40% since the inception of becoming a dry community (Hudson, 2011, p.viii).

The responsible service of alcohol in Aboriginal communities is based on property and economic rights. Due to poverty in Aboriginal communities, the rights to own property are minimised if not non-existent. Property rights in mainstream communities allow people social rights including (but not limited to) the ability to petition against irresponsible alcohol service and the ability to hold police and local government accountable (Hudson, 2011). For Aboriginal people to not have private property rights allows irresponsible serving of alcohol to occur without proper rights to enforce the restriction.

With communities being held at the mercy of particular people providing alcohol, there was no methods of controlling the excessive consumption. Without the proper methods of control, Aboriginal communities were spiraling further into dysfunction with alcohol-fuelled violence, sexual abuse, unemployment and non-economic participation. Thus, the introduction of dry communities evolved, which enforced total prohibition on alcohol.

6.2 Fitzroy Crossing Six Month Alcohol Prohibition

In 2008, Fitzroy Crossing was the focus of a coronial inquest into the deaths pertaining to suicides. The State Coroner, Alistair Hope concluded that many of the suicides were associated with chronic, high and risky use of alcohol as well as cannabis. The recommendations from the inquest were enforced, thus as of 2 October 2008 the restrictions under the *Liquor Control Act 1988* (WA) were in effect. The following restrictions under *section* of the *Liquor Control Act* were applied for six months (State Coroner of WA, 2008):

- The sale of packaged liquor: liquor delivered to or on behalf of the purchaser in sealed containers for consumption off the licensed premises;
- Liquor: a substance intended for human consumption which at 20° Celsius not exceeding 2.7% ethanol; and
- Lodger: person residing, whether casually or permanently, on the premises.

As per the definitions under *section 3*, the restriction on the sale of packaged liquor, exceeding a concentration of 2.7% ethanol in liquor at 20° Celsius is prohibited to any person, other than a lodger at licensed premises.

6.3 Fitzroy Crossing Social & Economic Impacts of being Dry

Prior to Fitzroy Crossing becoming a Dry Community, domestic violence and general community violence was common that the internal and external public thought that is was normal behaviour (Kinnane, Farrington , Henderson-Yates, & Parker, 2010). Two years after the restrictions were put in place; the majority of people in Fitzroy Crossing asserted that they had no desire to return to the conditions that previously existed (Kinnane, Farrington , Henderson-Yates, & Parker, 2010).

The progress gained from the prohibition on alcohol seen a reduction in public and domestic violence and people (more so young people) seeking employment and training, consequently actively participating in the community economy. After the initial six month ban was imposed the community again asked for another six months prohibition and the evaluation after the whole twelve months produced impressive social impacts (Kinnane, Farrington , Henderson-Yates, & Parker, 2010):

- Town was quieter;
- Public and anti-social behaviour had decreased;
- Domestic and public violence had decreased (but was up from the 12 month mark);

- Violence and humbug was reduced compared to before the restriction (but was up from the 12 month mark); and
- Individual and community safety and ability to carry out their work without violent threats or abuse continued to be significantly improved from before the restriction.

The local police had provided a progress report, which highlighted the reduction in violence amongst the community and directly towards them. Feedback from the local police was positive suggesting the social impacts outweighed any associated negativities, thus (Kinnane et.al, 2010, pp.30-31):

“The restrictions in Fitzroy enabled the Police to visit more often and for longer periods of time instead of responding to emergency situations all the time. This has resulted in one patrol per week over two to four days which gives Police the opportunity to work closely with the community. This is a model that the Police would like to repeat throughout the Valley if appropriately resourced”.

The social and economic impacts in Fitzroy Crossing were gradually increasing and encouraging community social and emotional wellbeing. This would further stimulate positive outcomes in community health.

6.4 Fitzroy Crossing Health Impact of being Dry

Before the restrictions on-call staff were almost completely with treating patients in the emergency department (ED) with patients presenting with alcohol related injuries with the majority suffering with serious wounds or trauma (Kinnane, Farrington, Henderson-Yates, & Parker, 2010). Kinnane et.al (2010, p. 32) stated, ‘...patients in the hospital who were admitted for maternity, other illnesses and treatment or other chronic conditions were not able to be given extra attention’.

Kinnane et.al (2010) confirmed the health staff perspectives of the restrictions; before and after:

Before restrictions health staff asserted:

- The majority of patients were alcohol-induced;
- Patients who were admitted to hospital for maternity, other illnesses and treatment of chronic conditions were not given extra attention;
- Common to treat between 30 and 40 alcohol related injuries per night;

- Staff recorded a very high level of job dissatisfaction and frustration at not being able to work more effectively with clients;
- Alcohol misuse was described as being chronic, chaotic and violent;
- Staff members attending ambulance call outs were attacked regularly, and at times the ambulance was unable to attend incidents without police support;
- The impact of alcohol consumption on children exhibited a very high proportion of children with Foetal Alcohol Spectrum Disorder (FASD).

After restrictions health staff asserted:

- The ED remained less tied up and this enabled action on preventative and chronic illness. There were fewer call-out to communities;
- Community health workers were able to focus on preventative health and this caused an increase in the improvement of general health of Fitzroy Crossing;
- Patients being admitted to hospital were more concerned about their underlying health problems, rather than presenting with trauma;
- There were fewer grandparents presenting with grandchildren and parents seemed to be taking more responsibility for their children and being more interested in their children's health;
- No more cases of people 'dumping' their children at the hospital because mothers were off somewhere drinking and no one was able to look after the children;
- The relationship with the drug and alcohol counsellor was also very positive with many clients being referred for detoxification and onward rehabilitation;
- Young women became more aware of FASD and were considering their pregnancies before drinking;
- Community was more stabilised;
- An increase in people using clinics;
- Easier to retain and recruit staff members (there had been a full complement of staff for two years);
- More fathers were bringing their children to the clinics;
- Children were presenting healthier with more money appearing to be spent on food and clothing;
- Less violence and noise in town and communities;
- More community harmony;
- Greater safety for health professionals;
- Less intoxicated clients;

- Children and families were getting along better; and
- More people appeared to be in work.

6.5 Nindiligarri Aboriginal Community Controlled Health Organisation

The Nindiligarri Aboriginal Community Controlled Health Organisation (Nindiligarri) observed less stress amongst their clients and families as alcohol was not affecting the community as individual, family and community priorities were not distorted by alcohol (Kinnane et.al, 2010, pp.38-39). Nindiligarri noticed that more Aboriginal people in Fitzroy Crossing requested health checks and if a chronic or other condition presented, the community was quick to do something about their health. Additionally, in 2009 Nindiligarri completed 600 health checks throughout the Fitzroy Valley with Aboriginal people being more aware and concerned with their health (Kinnane et.al, 2010, p.38). This shift in health priorities for the Aboriginal community allowed a whole of community approach to social and emotional wellbeing, with Nindiligarri noting (Kinnane et.al, 2010, p.38):

“Staff found that people were more focused on their health and on being healthier, more families were participating in cultural and other recreation activities, going out bush and hunting as a family without alcohol. People were increasing the demand for services, approaching community organisations and asking for support. People were being more proactive rather than reactive”.

In addition to noticing positive client response to health, Nindiligarri also worked with the Drug and Alcohol Office (DAO) of Western Australia, the local police and the Fitzroy Crossing Inn on an education campaign aimed at FASD. Messages pertaining to FASD were placed on glasses used by patrons of the Fitzroy Crossing Inn (Kinnane et.al, 2010, p.38). In May 2010, Nindiligarri initiated a research community information project called ‘Liliwan Project’, which was aimed at educating and awareness of FASD – especially in a time when people were becoming more concerned about their health and the impacts of alcohol (Kinnane, 2010).

6.6 Detriments of Dry Communities

The detriments of dry communities have been widespread throughout both Fitzroy Crossing and Queensland’s Aurukun (which is classed as a dry community). Once the restrictions were in place, alcohol once again became a commodity for people to buy alcohol legally in other towns and illegally sell it in dry communities (Hudson, 2011) – this process has been dubbed as sly grogging.

Sly grogging had become an issue in towns such as Fitzroy Crossing and Aurukun, where police are now targeting and trying to eliminate the illegal sale of alcohol to people who are

dependent (Parke, 2014). Fitzroy Crossing has had some positive progress in tackling sly grogging with six successful prosecutions in the past year of people illegally trading alcohol (Parke, 2014).

Displacement of social drinking is also another detriment of dry communities, whereas, people are gathering in 'drinking camps' outside of town in order to abuse alcohol outside the parameters of the law and restriction (Hudson, 2011). This not only impels excessive drinking outside of town but creates a social dichotomy between Aboriginal people who are campaigning for dry communities and those who force the old lifestyle of violence and alcohol dependence (Hudson 2011 and Parke 2014).

6.7 Increased exposure to the justice system

Fitzroy Crossing has seen people undermine the law and increase sly grogging, as such Hudson (2011, p. 18) stated,

"In Western Australia, more people are driving from Fitzroy Crossing to Derby to buy full-strength alcohol, and people are giving their EFTPOS cards and PINs to those travelling to the towns to purchase alcohol for them. Two years after the introduction of restrictions, people are getting better at circumventing the law; now, when drivers collect EFTPOS cards from others, they put labels on the cartons saying which carton belongs to whom, and match each carton with each EFTPOS card to show the police they are buying alcohol for others and not to sell illegally".

Fitzroy Crossing is hard-pressed to prosecute people for sly grogging, but evidence suggests that six successful prosecutions in the past year (Hudson, 2011) has been an advancement in community protection and awareness.

6.8 Alcohol Management Plans: Legislative Authority

Aurukun is a dry community in Queensland that operates under an Alcohol Management Plan (AMP), which has authority under the *Indigenous Communities Liquor Licences Act 2002* (Qld). As construct of the *Indigenous Communities Liquor Licences Act*, AMPs included regulations that imposed restricted areas to consume alcohol (Cunneen, Collings, & Ralph, 2005). The AMPs also enforced the powers of the State in relation to management, consumption and possession of alcohol in Aboriginal communities; and with these powers a range of offences regarding breaches of AMPs (Cunneen, Collings, & Ralph, 2005). Amendments to particular legislation allowed specific references to Aboriginal communities as part of a legislative response to alcohol abuse, as such Cunneen, Collings & Ralph, (2005, p. 152) stated,

“The Community Services (Aborigines) Act 1984 and the Community Services (Torres Strait Islander) Act 1984 were amended in 2004 to ban the possession of homebrew kits, home-brew concentrate and the possession and supply of homemade liquor in a prescribed community area. The new laws do not apply to an area until the area is prescribed under a regulation. The Community Services (Aborigines) Act 1984 has been subsequently amended and renamed the Aboriginal Communities (Justice and Land Matters) Act 1984 and amended in 2004 prescribing the communities of Mornington Island and Aurukun to effect the home-brew ban”.

Palm Island woman, Joan Maloney was charged with possessing a bottle of bourbon and rum in a prescribed area in 2010, Ms Maloney brought her case before the High Court claiming that the AMPs violated the *Racial Discrimination Act 1975* (Cth) (Watt, 2012). Ms Maloney’s attempt to appeal was quashed as the *Racial Discrimination Act* allowed minority groups to be exempt when there is a social harm that needs State intervention. More over the Crown’s defendant reminded the High Court that (Watt, 2012),

“...restricted areas a geographically defined and that the AMPs apply to all people within these boundaries, regardless of their skin hue...these areas just happen to be all Aboriginal communities”.

Ms Maloney’s case was not successful as her attempt to condemn AMPs as racially discriminatory did not hold strong as a group of Aboriginal people were perceived as needing State assistance to incite positive and long-lasting social and emotional wellbeing in the community.

In the case of *Callope v Senior Constable B Elseley* (unreported, District Court of Queensland Cairns, White DCJ, 8 March 2005) an elderly man Mr Callope (a resident of Napranum) had been an alcoholic for several years. In 1998, Mr Callope was convicted to a violent offence but over the next 15 years Mr Callope had not been convicted of any other offences. Until the introduction of alcohol restrictions in the community, Mr Callope [in 2004] was arrested and sentenced for two offences under the *Liquor Act 1992* (Qld). Watson (2009) summarised the case: ‘the first of the two offences arose from his possess of a single can of beer in a restricted area; for this offence he was sentenced to one month’s imprisonment and forty weeks probation. The second offence took place the following day, when Mr Callope was found in possession of a cask of wine. For the second offence, he was sentenced to six weeks imprisonment, followed by 42 weeks probation. Although the sentences were overturned on appeal, the case highlights the potential for alcohol restrictions to expose already vulnerable people to further risks of incarceration’.

The legislation was put in affect in order to decrease harmful alcohol consumption [mainly in Aboriginal communities]. At no point does the legislation seek to abhorrently punish and brand alcoholics [in this case Aboriginal alcoholics] as criminals. The legislation gave authority to minimise risky drinking not punish people who have drinking problems and carrying one can of beer, which White DCJ [5] concurred.

6.9 Holistic and Justice Agreements

Cunneen, Collings & Ralph (2005, p.2) provided guiding principles which were identified after evaluating AMPs and dry communities. The following guiding principles were created after consultation with Aboriginal communities stressed that AMPs were an imposed construct by the government without substantial community support or consultation (Cunneen, Collings & Ralph, 2005, p. 159). Aboriginal communities under AMPs were concerned that the imposition of AMPs [like Fitzroy Crossing] encouraged displacement of drinking camps; and breach and penalties were unnecessarily punitive (Cunneen, Collings, & Ralph, 2005). However, the AMPs improved social wellbeing by more money being saved, thus local stores were commenting on food being brought, which meant less break-ins by children trying to obtain food (Cunneen, Collings, & Ralph, 2005). The following guiding principles were developed by Cunneen, Collings & Ralph (2005, p.2) after extensive consultation and evaluation of government imposed AMPs:

1. Aboriginal Participation;
2. Recognition of culture;
3. Acknowledgement of the Past;
4. Respect for Aboriginal cultural values;
5. Equality before the law;
6. Improved Coordination;
7. Empowerment and self-determination;
8. Underlying issues; and
9. Royal Commission.

These guiding principles reflected Aboriginal communities and the process of encouraging a working relationship with the government instead of government imposition – which normally stains effective working relationships and programs. This approach is holistic in nature, where both Aboriginal and non-Aboriginal people working in communities expressed the need for rehabilitation centres should be implemented into communities. However, according to the guiding principles provided by Cunneen, Collings & Ralph (2006), rehabilitation centres should be renamed and reorganised to be holistic healing centres and more preventative work should be introduced instead of imposing restrictions that did little to counter alcohol consumption.

7 FOETAL ALCOHOL SPECTRUM DISORDERS

7.1 Categories and Symptoms of FASD Diagnoses

FASD collectively has three diagnoses all of which fall under the umbrella of FASD but with specific disparities which confuse clinical and community diagnoses (Mutch , Watkins, Jones , & Bower, 2013). The three diagnoses of FASD include:

1. Fetal [sic] Alcohol Syndrome (FAS);
2. Partial Fetal [sic] Alcohol Syndrome (PFAS); and
3. Neurodevelopmental Disorders.

FASD is a non-diagnostic term that encompasses a range of disabilities, which occurs as a direct result of alcohol consumption while in utero. The damage associated with FASD may cause irreversible damage to the brain and other organs of the foetus, thus disturbing development of an embryo or foetus (Mutch , Watkins, Jones , & Bower, 2013).

Alcohol is a teratogen, which is able to cause malformation and/or continual growth interruptions once a baby is born and in its early developmental years. As such, the Commonwealth Government Department of Health and Ageing (DoHA) produced a literature review detailing the diagnosis of FASD based on a set of criteria pertaining to the abnormalities in three categories (DoHA, 2002):

1. Growth retardation;
2. Characteristic facial features (small eye slits, thin upper lip and diminished groove between nose and upper lip); and
3. Central nervous system anomalies (including abnormalities of structure and function e.g. intellectual impairment).

Mutch (2013) went further and described the abnormalities of brain structure and/or function of children suffering from FASD resulting in various learning and development problems; including (but not limited to) developing mental issues specifically:

- Poor hand-eye coordination;
- Fine motor function;
- Inability to complete complex tasks that involve planning and judgment; and

- Social interaction complications.

The brain of child with FASD is remarkably smaller than that of a healthy child. The brain is affected in size and ability to maintain healthy functions to ensure emotional and social wellbeing.

Image 3: Disparities between a healthy and FASD 6 week old brain



Image 3: Disparities between a healthy and FASD 6 week old brain (Image 3) (<http://www.acbr.com/fas/fasbrail.jpg>) illustrates the key differences and inability of a child suffering with FASD to perform at the same level as a healthy child who has had no pre-conception, in vitro or birthing exposure to alcohol. Nonetheless, FASD and the implications of alcohol during pregnancy have been associated as a maternal issue with no substantial reference to paternal alcohol consumption.

7.2 Maternal and Paternal Alcohol Consumption & FASD

In most cases FASD is associated with maternal alcohol consumption rather than paternal consumption. Consequently, the burden of assumption is directly targeting Aboriginal women [and women in general] as the cause of FASD. Mutch et.al (2013, pp.14-16) described FASD being maternally attributable by the following statements,

“Development of a fetus [sic] in utero: cell growth occurs at different stages and rates as a fetus matures. At critical stages this process can be disrupted with permanent impacts through the transfer of even small amounts of alcohol through the placenta” and “During weeks 27 to 30 of pregnancy, fetal [sic] brain growth occurs at its fastest rate. Drugs taken by a pregnant woman follows the same route as oxygen and nutrients which are needed for growth and development, crossing the placenta”.

Comments such as Mutch et.al (2013) assume that FASD is a maternal problem that women are solely the cause of. This assumption is further perpetuated with comments from the following:

“Some drugs taken during pregnancy can affect the fetus [sic] in several ways, for example:

- *They act directly on the fetus [sic], causing damage, abnormal development (leading to birth defects), or death;*
- *They can alter the function of the placenta, usually by causing blood vessels to narrow (constrict) and thus reducing the supply of oxygen and nutrients to the fetus [sic] from the mother. Sometimes the result is a baby that is underweight and underdeveloped; and*
- *They can cause the muscles of the uterus to contract forcefully, indirectly injuring the fetus by reducing its blood supply or triggering preterm labour and delivery” (Merck).*

“The fetus [sic] is unable to break down alcohol in the way that an adult does and so the blood alcohol level of the fetus [sic] becomes equal to or greater than the blood alcohol level of the mother. Further the fetus’ blood alcohol level remains high for a longer period of time” (DoHA, 2002).

Both of these statements imply alcohol consumption is maternal; affecting the foetus through direct contact via internal muscles or the placenta. Vicki O’Donnell, CEO of the Kimberley Aboriginal Medical Services Council (KAMSC) (and former Chairperson of AHCWA) concurred that maternal alcohol consumption was a contributor to FASD but included paternal alcohol consumption as a cause of FASD (O’Donnell, 2014). As such, the inclusion of paternal research contributing to FASD should be acknowledged if not investigated to ensure full coverage of FASD is taken into consideration.

Paternal alcohol consumption has been associated with genetic conditions, birth defects, malformations and conception. More noticeably, paternal alcohol consumption has contributed to neonatal and reduced fertility, leading to a higher foetal mortality rate (Cicero, Nock, O'Connor, Sewing, Adams, & Meyer, 1994) and (Tanaka, Suzuki, & Arima, 1982). There has been research conducted that makes a direct link to paternal alcohol consumption with the following foetal symptoms (Cicero, Effects of paternal exposure to alcohol on offspring development, 1994), (Gottesfeld & Abel, 1991) and (Gearing, McNeill, & Lozier, 2005):

- Physical malformations;
- Increased adrenal weights at decreased testosterone levels at weaning;
- Decreased testosterone levels at maturity;
- Increased susceptibility of the immune system;
- Hyperactivity;
- Changes in adult locomotor activity;
- Decreased ability to cope with stress; and
- Learning and memory deficits.

It has also been noted that with males who use alcohol before and during pregnancy have done so with semen that possess toxins, thus leading to the potential damage of a child's genetic material (Gearing et.al, 2005, p.3). Paternal alcohol consumption leads to testicular dysfunction, which increases the presence of abnormal sperm. For a male to reproduce with abnormal sperm leads to an increased risk of spontaneous abortions (Gearing et.al, 2005, p.3). However, it is strongly noted that, *'those are most disadvantaged by poverty, bear the greatest risk of FASD'* (Armstrong & Abel, 2000).

Both maternal and paternal alcohol consumption affects the development of a foetus as well as disturbing the cognitive development of the brain. Accordingly, it is not surprising that females are focused on as there is the direct link via placenta, yet males contribute to spontaneous abortions and malformations just the same. Suffice to say; although both parents contribute to FASD it is overwhelming the effects of poverty have on people inducing FASD.

7.3 FASD in the Community

Fitzroy Crossing noted that before the alcohol restrictions were enacted, a high proportion of children were presenting with FASD and given the high number of children with FASD in the community a life-time's amount of work will be needed to help those children affected (Kinnane, Farrington, Henderson-Yates, & Parker, 2010).

Aboriginal communities are more aware of FASD in their communities as FASD has only recently been identified and noticeable in the medical industry. FASD is an intergenerational issue, which needs to be addressed not only through the mother and child but inclusive of fathers, grandparents and a whole of community approach should be taken in order to educate and decrease the number of FASD children. Both Hudson (2011) and Kinnane et.al (2010) asserted that a FASD strategy was needed and governments should support these types of strategies as the foundation of future development and improvement in communities. Whereas, government support and community encouragement would ensure a generation of solid social structures, leadership and healthy investments for intergenerational change.

Fitzroy Crossing applauded the alcohol restrictions but noted that the increase and/or lack of FASD awareness in the community was in dire need of mitigation (Kinnane et.al, 2010). FASD in communities needs to be addressed, however in saying that, not only in Aboriginal communities – but non-Aboriginal communities need to be educated about FASD, thus a whole of community approach needs to be taken.

In 2012, a media report suggested that half of the babies born at Fitzroy Crossing were born with disabilities stemming from FASD (Skelton, 2012). Due to patterns changing over recent years an increase in young female drinkers has occurred, whereas the pattern in young females has increased in both Aboriginal and non-Aboriginal women but more noticeable in Aboriginal women. Mutch (2013, p.41) expressed that 1 in 8 Aboriginal women compared to 1 in 12 non-Aboriginal women reported as consuming alcohol during their first antenatal visit. At 36 weeks a decrease of 8.4% of Aboriginal women and 4.2% of non-Aboriginal women continued to drink alcohol. Furthermore, Mutch (2013) commented that a majority of women either reduced the alcohol consumption during pregnancy or abstained.

Albeit, even though there was a reduction in alcohol consumption during pregnancy, there was a disturbing rate of binge drinking in females, thus 4 to 20% of non-Aboriginal women reported to binge drinking during pregnancy while Aboriginal women accounted for 22% being report (Mutch, 2013, p.43). The question remains why do women binge drink or drink excessively during pregnancy needs to be tackled.

7.4 Confusion of Why Women Consume Alcohol during Pregnancy

The Australian Government guidelines on consumption during pregnancy has had considerable changes over the years. Consequently, between 1992-2001 it was recommended that women do not consume alcohol while pregnant (Maguire, 2010). In late 2001, the guidelines were revised to suggest that small amounts of alcohol during pregnancy were safe. Again, in 2009 (the current guidelines) recommended no alcohol consumption

during pregnancy (Maguire, 2010). Mutch et.al (2013, pp.43-44) identified that a lack of awareness regarding alcohol consumption and the impacts on a foetus were prevalent, also the following were also identified as why women drank during pregnancy:

- A woman may be unaware she is pregnant, especially in the early weeks;
- Trauma factors which contribute to a woman's emotional and/or physical dependency on alcohol; and
- A cultural context which does not support a woman to stop drinking when pregnant.

The Standing Committee of Social Policy and Legal Affairs (SCSPLA) previously led an inquiry titled, 'FASD: The Hidden Harm, Inquiry into the prevention, diagnosis and management of Fetal Alcohol Spectrum Disorders'. A quote that was used to assist the recommendations regarding why women consume alcohol while pregnant was:

"It would be a very unusual woman who actually deliberately did it. I am sure there are, but we are talking about the majority. The majority do not set out to hurt their children. They drink either because they are not aware of the full impact on their children and their family or because they are in a situation of domestic violence where they just cannot get out of that cycle of drinking. There is a reason and we need to find out what the reason is..." (House of Representatives Standing Committee of Social Policy and Legal Affairs, November 2012).

Cultural expectations of drinking are due to social dysfunction, norms and behaviours. The patterns of Aboriginal women drinking alcohol while pregnant was due to cultural expectations, which stemmed from domestic violence (Mutch et.al, 2013). Furthermore, it has been noted that women may not change their daily and/or social patterns of drinking alcohol unless of course there was a distinct cultural shift in community attitudes to support them to do so (Callinan & Room, 2012).

7.5 Health Professionals confused over Guidelines

Australian health professionals are confused with the Commonwealth guidelines along with women. This does not incite faith in a system that is supposed to support women (in particular Aboriginal women) in cultural change to ensure a decrease in FASD babies (Mutch et.al, 2013, p.53). Health professionals are not aware of the guidelines and its amendments, resulting in pregnant women not being given efficient information to assist with a healthy pregnancy. A recent evaluation of the promotion of the guidelines reported that health professionals lacked the information, updates and educational awareness of alcohol consumption and pregnant women (Mutch et.al, 2013), thus, "...substantial evidence shows

that health professionals often lack the skills or do not consider it relevant to discuss alcohol consumption with a woman who is pregnant” (Mutch et.al. 2013, p.54).

The Telethon Institute reported that a survey in 2007 in Western Australia discovered that half of the health professionals surveyed (who cared for pregnant women) regularly asked women about alcohol consumption during their pregnancy (Mutch et.al, 2013). However, only 33% of health professionals provided information to pregnant women about the effects on the foetus and FASD to expecting mothers (Mutch et.al, 2013, p.54). Additionally, Mutch et.al (2013, p.55) stated,

“It is apparent that across the field of health professionals, there is a number of practitioners who lack up to date information, who spread misinformation or who are reluctant to raise the topic of alcohol consumption with women who are pregnant or planning to become pregnant. This is a serious failing and is no doubt a major contributor to the lack of public awareness of the risks of FASD, and to the myths and the misinformation that currently exist across the wider community”.

If health professionals lack the ability and information to discuss alcohol consumption and FASD with pregnant women and men, then there is little to no hope of Aboriginal communities who lack ACCHOs in their communities to receive education and awareness surrounding FASD.

7.6 Ord Valley Aboriginal Health Service

The Ord Valley Aboriginal Health Service (OVAHS) has implemented a FASD prevention program from 2009, which has recently been funded until 2015. The goal of the FASD program is to promote FASD throughout the community [and surrounding communities] so that people are aware of what’s happening and what FASD is (Goodwin, 2014). The success of OVAHS FASD prevention programs is that it takes on a community approach by presenting workshops with local service providers; local people; clients; schools; public events and community events.

Helen Goodwin (RN/RM) who is the OVAHS FASD Project Coordinator asserted that the success of the program may possibly derive from OVAHS’ contraception push in the community. With the introduction of Implanon (3 years continuous birthing prevention) women [including young girls] are choosing Implanon as an option to prevent pregnancy. Accordingly, a lot of women who have recently given birth have opted to use Implanon before they go home from the hospital. Goodwin (2014) expressed that women who chose to use Implanon were empowering themselves, especially in the process of wanting to have another child. Thus, before the Implanon was removed the OVAHS health workers would

educate the women around alcohol consumption and FASD. The results of doing this has been that some of the women in Ord Valley will admit they were not ready to give up alcohol and would make the decision to have it removed.

Goodwin (2014) had identified a group of women who would not drink or choose not drink while planning their pregnancy, however due to dependent relationships, the culture of domestically violent relationships would result in the woman being forced [by her partner] to drink while pregnant.

The FASD situation in Ord Valley has improved and it is due to the FASD prevention program that has been implemented. The success of this program has recently been recognised by the Commonwealth; as such OVAHS has received national recognition for this program and has been asked for this program to be used in other services nationally.

7.7 Government recognition of Disability

The Australian government does not currently recognise FASD as a disability (House of Representatives Standing Committee of Social Policy and Legal Affairs, November 2012). Mutch et.al (2013, p.1) confirmed this statement by stating,

"People with FASD commonly have cognitive impairment on standardised testing, but their intelligence quotient (IQ) is not often below 70 and so does not meet the definition of an intellectual disability".

Families who have children with FASD feel as though there is no hope in a system that does recognise FASD as a disability. Moreover, it has been noted that when families present with FASD children professional services usually assume the child's behaviours are based on environmental factors (i.e. poor parenting choices, dysfunctional families), rather than concede FASD as a reason to below normal brain and cognitive functioning (House of Representatives Standing Committee of Social Policy and Legal Affairs, November 2012).

Recently, an Aboriginal woman was imprisoned in a Western Australian prison without being charged for 18 months. Roseanne Fulton, 24, was found unfit to stand trial due to her mental impairment and would remain imprisoned until suitable accommodation was found for her (The Koori Mail, 2014). The fact that Ms Fulton has cognitive disabilities as a result of FASD, the Australian legal system willfully acknowledged Ms Fulton's disabilities as she could not stand trial (The Koori Mail, 2014).

FASD is not recognised therefore will not get the appropriate support mechanisms other disabilities access via the government. However, the National Disability Insurance Scheme



(NDIS) is planned to be rolled out in 2014, whereas the NDIS, *“...will ensure that people with significant and permanent disability receive the care and support they need over their lifetimes, regardless of where they live or how they acquired their disability”* (House of Representatives Standing Committee of Social Policy and Legal Affairs, November 2012).

The Human Rights Commission of Australia is keen to support the NDIS and include FASD as a disability. The government needs to recognise FASD as a disability to ensure that parents and carers are given the same support and recognition as others with children with disabilities. This would also mean that children and adults suffering with FASD would not be put into justice systems as a result of cognitive impairment and become criminals as opposed to people with disabilities.

The Aboriginal Health Council of Western Australia advocates on behalf of 20 Aboriginal Medical Services in Western Australia, to ensure that the health needs of the State's communities are represented at all levels.

Bibliography

- ABS. (2010). *4704.0 The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*. Canberra: ABS.
- ABS. (2012). *4338.0 Profiles of Health, Australia 2011-13*. Canberra : Australian Bureau of Statistics.
- AHCWA. (n.d.). *Aboriginal Health Council of Western Australia - Mission Statement*. Retrieved January 9, 2014, from Aboriginal Health Council of Western Australia: <http://www.ahcwa.org.au/index.php/about-us/mission-statement>
- AIHW. (2013). *Life expectancy* . Retrieved April 7, 2014, from Australian Government: Australian Institute of Health and Welfare: <https://www.aihw.gov.au/deaths/life-expectancy/>
- Armstrong, E. M., & Abel , E. L. (2000). Fetal Alcohol Spectrum Disorder: the origins of a moral panic. *Alcohol and Alcoholism*, Vol.35(3), p.280.
- Assembly, G. (1966). *International Covenant on Economic, Social and Cultural Rights*. New York: United Nations.
- Assembly, G. (2008). *United Nations Declaration on the Rights of Indigenous Peoples*. New York: United Nations.
- Beckett, J., & Reay, M. (1964). *Aborigines, alcohol and assimilation in Aborigines Now*. Sydney: Angus & Robertson.
- Brady, M. (2007). Equality and difference: persisting historical themes in health and alcohol policies affecting Indigenous Australians. *Journal of Epidemiology and Community Health* , Vol. 61, pp. 759-763.
- Callinan, S., & Room, R. (2012). *Alcohol consumption during pregnancy: Results from the 2010 National Drug Strategy Household Survey*. Canberra : Foundation for Alcohol Research and Education .
- Cicero , T. J. (1994). Effects of paternal exposure to alcohol on offspring development. *Alcohol Health & Research World*, Vol.18(1), pp.37-41.
- Cicero, T. J., Nock, B., O'Connor , L. H., Sewing, B. N., Adams, M. L., & Meyer, E. R. (1994). Acute paternal alcohol exposure impairs fertility and fetal outcome. *Life Sciences*, pp.33-36.
- Cunneen, C., Collings, N., & Ralph, N. (2005). *Evaluation of the Queensland Aboriginal and Torres Strait Islander Justice Agreement*. Sydney : Institute of Criminology: Uni of Sydney Law School .
- DoHA. (2002). *Fetal Alcohol Syndrome: A Literature Review*. Canberra: Commonwealth Department of Health and Ageing .
- Duckworth, S. V., & Norton , T. L. (2000). Fetal Alcohol Spectrum Disorder and Fetal Alcohol Effects--Support for Teachers and Families . *Dimensions of Early Childhood*, Vol. 28(3), pp.19-23.
- Eggleston , E., Hetzel, B. S., Dobbin, L., & Lippmann, L. (1974). *Legal Controls on alcohol in Better health for Aborigines?* St Lucia: University of Queensland Press.
- Freeland, M. (1966). *The Australian Publications*. London: Melbourne University Press.
- Friedler, G. (1996). Paternal exposures: Impact on reproductive and developmental outcome - An Overview. *Pharmacology Biochemistry and Behavior*, Vol. 55(4), p.803.

- Gearing , R. E., McNeill, T., & Lozier, F. A. (2005). *Father involvement and fetal alcohol spectrum disorder: developing best practices*. Toronto : Hospital for Sick Children .
- Goodwin, H. (2014, March 20). FASD Project Coordinator . (N. Currie, Interviewer)
- Gottesfeld, Z., & Abel, E. L. (1991). Maternal and paternal alcohol use: effects on the immune system of the offspring. *Life Sciences*, Vol.48(1), pp.1-8.
- Government of WA Drug and Alcohol Office. (n.d.). *Alcohol Use Statistics* . Retrieved February 25, 2014, from Alcohol Think Again : <http://alcoholthinkagain.com.au/Alcohol-Related-Information/Alcohol-Use-Statistics.aspx>
- Grey, D., Stearne, A., Wilson , M., & Doyle, M. (Indigenous-specific alcohol and other drug interventions - Research Paper No. 2). 2010. Canberra: Australian National Council on Drugs .
- H. G., & Goodwin , H. (2014, March 20). FASD Project Coordinator. (N. Currie, Interviewer)
- House of Representatives Standing Committee of Social Policy and Legal Affairs. (November 2012). *FASD: The Hidden Harm, Inquiry into the prevention, diagnosis and management of Fetal Alcohol Spectrum Disorders*. Canberra : Commonwealth of Australia.
- Hudson, S. (2011). *Alcohol Restriction in Indigenous Communities and Frontier Towns*. St Leonards : Centre for Independent Studies .
- Hudson, S. (2011). *Alcohol Restrictions in Indigenous Communities and Frontier Towns*. Australia: Centre for Independent Studies.
- Karvelas , P. (2014, February 14). *Inquiry to examine the harmful use of alcohol in indigenous communities*. Retrieved February 24, 2014, from The Australian: www.theaustralian.com.au/national-affairs/policy/inquiry-to-examine-the-harmful-use-of-alcohol-in-indigenous-communities/story-fn9hm1pm-1226827347092
- Kelm, M. E. (1998). *Colonizing bodies: Aboriginal health and healing in British Columbia, 1900-50*. Vancouver : UBC Press.
- Kinnane, S., Farrington , F., Henderson-Yates, L., & Parker, H. (2010). *Fitzroy Valley Alcohol Restriction Report, December 2010: 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*. Perth : The University of Notre Dame Australia - The Drug and Alcohol Officer of Western Australia.
- Langton, M. (1993). Rum, seduction and death: 'Aboriginality' and alcohol. *Oceania*, Vol. 52, pp. 195-206.
- Latimer, J., Carter, M., Oscar, J., Fitzpatrick , J., Ferreira, M., Kefford, M., et al. (2011). The Lililwan Project: the power of diversity in achieving a common goal . *11th National Rural Health Conference* (p. 2). Perth : National Rural Health .
- Maguire, B. (2010). *The Longitudinal Study of Australian Children Annual Statistical Report*. Retrieved February 28, 2014, from Growing Up In Australia: http://www.growingupinaustralia.gov.au/pubs.ast/2010/asr2010k.html#table11_1
- Merck . (n.d.). *The Merck Manual Home Health Handbook, Drug use during Pregnancy*. Retrieved February 27, 2014, from Merck Manuals: <http://www.merckmanuals.com/home>
- Midford, R. (2005). Australia and alcohol: Living down the legend. *Addiction* , Vol. 100(7), pp. 891-896.

- Mutch, R., Watkins, R., Jones, H., & Bower, C. (2013). *Fetal Alcohol Spectrum Disorder: knowledge, attitudes and practice within the Western Australian justice system*. Perth : Telethon Institute for Child Health Research - Centre for Child Health Research .
- NIDAC. (2009). *Bridges and barriers: addressing Indigenous incarcerations and health*. Canberra : Australian National Council on Drugs.
- O'Brien, A. (2010, August 5). *Aboriginal communities ask government for drink*. Retrieved February 26, 2014, from The Australian: <http://www.theaustralian.com.au/new/nation/aboriginal-communities-ask-governmnet-for-drink-bans/story-e6frg6nf-1225901336628>
- O'Donnell, V. (2014, April 9). CEO of KAMSC . (N. Currie, Interviewer)
- Parke, E. (2014, March 12). *Sly grogging on the rise in Fitzroy Crossing* . Retrieved March 12, 2014, from ABC Online: <http://www.abc.net.au/news/2014-03-11/sly-grogging-on-the-rise-in-fitzroy-crossing/5312834>
- Reading, C., & Wien, F. (2013). *Health Inequalities and Social determinants of Aboriginal peoples' health*. Prince George BC: National Collaborating Centre for Aboriginal Health .
- Room, R. (1988). The dialectic of drinking in Australian life: from the rum corps to the wine column. *Australian Drug and Alcohol Review*, Vol. 7, pp. 413-437.
- Savitz, D. A., Schwingl, P. J., & Keel, M. A. (1991). Influence of paternal age, smoking and alcohol consumption on congenital anomalies. *Teratology* , Vol.44(4), pp.429-440.
- SCRGSP. (2009). *2009 Overcoming Indigenous Disadvantage: Key Indicators* . Canberra : Steering Committee for the Review of Government Service Provision .
- Senior, K., & Chenhall, R. (2008). Lukumbat marawana: A changing pattern of drug use by youth in a remote Aboriginal community. *Australian Journal of Rural Health*, Vol. 16, pp. 75-79.
- Skelton, R. (2012, November 12). Grog Hits Indigenous Babies. Australia: Sydney Morning Herald.
- State Coroner of WA. (2008). *Inquest into Deaths and records of investigation into death, Ref No: 37/07*. Perth : Coroner's Court of Western Australia .
- Stockwell, T. (2004). Australian alcohol policy and the public interest: a brief report card. *Drug and Alcohol Review*, Vol. 23, pp. 377-379.
- Sutton, C. (2014). *Violence against Aboriginal women 80 times worse*. Retrieved February 8, 2014, from News Dot Com: <http://www.news.com.au/national/violence-against-aboriginal-women-80-times-worse/story-e6frfkp9-1226661209335>
- Sutton, P. (2009). *The Politics of Suffering: Indigenous Australians adn the End of the Liberal Consensus*. Melbourne : Melbourne Uni Press.
- Tanaka, H., Suzuki, N., & Arima, M. (1982). Experimental studie on the infludence of male alcoholism on fetal development. *Brain & Development*, Vol.4(1), pp.1-6.
- The Australian. (2007, March 7). *Culture of denial* . Retrieved April 8, 2014, from The Australian: <http://www.theaustralian.com.au/arts/culture-of-denial/story-e6frg8px-1111113048370>
- The Koori Mail . (2014, March 26). Govt acts on Fulton . Lismore : Koori Mail .
- WA Now and Then. (2013, January 11). *A Timeline of major events in Western Australia's History*. Retrieved April 4, 2014, from Time-Line: <http://www.wanowandthen.com/timeline.html>
- Ward, R. (1978). *The Australian Legend*. Melbourne: Oxford University Press.

- Waterson, E. J., Evans, C., & Murray-Lyon, I. M. (1990). Is pregnancy a time of changing drinking and smoking patterns for fathers as well as mothers? An initial investigation . *British Journal of Addiction* , Vol. 85(3), pp.389-396.
- Watson, N. (2009). Regulating Alcohol: One Step Forward, Two Steps Back? *IndigLawB* 16, np, 7(11).
- Watt, E. (2012, December 18). *Is it racist to ban alcohol from some Aboriginal communities?*
Retrieved February 26, 2014, from ABC Online:
<http://www.abc.net.au/unleashed/4433434.html>
- Wilkinson, R. G., & Marmot, M. (2003). *Social determinants of health: the solid facts (2nd ed)*.
Copenhagen : World Health Organisation Regional Office for Europe .
- Wilson, M., Stearne, A., Gray, D., & Saggars, S. (2010). *The harmful use of alcohol amongst Indigenous Australians*. Retrieved February 25, 2014, from HealthInfoNet:
http://www.healthinfo.net.ecu.edu.au/alcoholuse_review
- Zubrick, S. R., Dudgeon , P., Gee, G., Glaskin , B., Kelly, K., Paradies, Y., et al. (n.d.). *Social determinants of Aboriginal and Torres Strait Islander Social and Emotional Well-Being*.
Retrieved February 24, 2014, from Working Together :
<http://www.childhealthresearch.org.au/media/54874/Chapter6.pdf>