Aboriginal Peak Organisations Northern Territory

An alliance of the CLC, NLC, CAALAS, NAAJA and AMSANT

Aboriginal Peak Organisations (NT)

Submission to the Australian House of Representatives Standing Committee on Social Policy and Legal Affairs Inquiry into Foetal Alcohol Spectrum Disorder

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SUBMISSION FROM APO NT TO THE AUSTRALIAN HOUSE OF REPRESENTATIVE STANDING COMMITTEE ON SOCIAL POLICY AND LEGAL AFFAIRS INQUIRY INTO FOETAL ALCOHOL SPECTRUM DISORDER

DECEMBER 2011

Aboriginal Peak Organisations Northern Territory (APO NT) welcomes the opportunity to make a submission to the Australian House of Representative Standing Committee on Social Policy and Legal Affairs Inquiry into Foetal Alcohol Spectrum Disorder (FASD).

The Northern Territory has the second highest alcohol consumption in the world. Misuse of alcohol has devastating health and social consequences for NT Aboriginal communities. FASD is one of many alcohol related health issues faced by Aboriginal people in the NT. APO NT believes that addressing alcohol and drug misuse, along with the many health and social consequences of this misuse, can only be achieved through a multi-tiered approach.

To address alcohol and drug misuse within Aboriginal and Torres Strait Islander communities, social and structural determinants of mental health must be addressed. Public health policies and clinical services aiming to impact on FASD must also be guided by the evidence base and integrated into broader policies that are working to overcome Aboriginal disadvantage. Recognition of the impacts of FASD and its implications on people's behaviours and its contribution to offending is integral. Current practices of FASD being largely ignored in the criminal justice system due to the dearth of intervention and management therapies only serves to further isolate and institutionalise individuals affected by FASD.

1 About APO NT

APO NT is broadly representative of all Aboriginal peoples in the Northern Territory. Formed in October 2010, APO NT is an alliance between the Northern Land Council (NLC), Central Land Council (CLC), Aboriginal Medical Services Alliance Northern Territory (AMSANT), North Australian Aboriginal Justice Agency (NAAJA) and Central Australian Aboriginal Legal Aid Service (CAALAS).

APO NT is working to develop constructive policies on critical issues facing Aboriginal people in the Northern Territory and to influence the work of the Australian and Northern Territory governments. As representatives from peak organisations in the Northern Territory,

we share the aim of protecting and advancing the wellbeing and rights of Aboriginal and Torres Strait Islander people and communities. We also aim to provide a representative voice for Aboriginal people in the Northern Territory and to enable effective communication and information distribution between and within communities and Aboriginal organisations.

AMSANT:

AMSANT is the peak body for Aboriginal Community Controlled Health Services in the Northern Territory. AMSANT has 25 member services providing comprehensive primary health care throughout the Northern Territory. AMSANT has a long record of advocating for evidence-based alcohol and other drug policies and service initiatives. It aims to improve the health of Aboriginal people in the Northern Territory through promoting and extending the principle of local Aboriginal community control over primary health care services to Aboriginal people. AMSANT aims to alleviate the sickness, suffering and disadvantage, and to promote the health and well-being of Aboriginal people of the Northern Territory through the delivery of health services and the promotion of research into causes and remedies for illness and ailments found within the Aboriginal population of the Northern Territory.

CAALAS:

The Central Australian Aboriginal Legal Aid Service strives for justice, dignity and equal rights and treatment before the law for Aboriginal people in Central Australia. CAALAS provides high quality, culturally appropriate and readily accessible legal services (in the areas of criminal, civil, family and welfare rights law), legal education, social justice advocacy and preventative and early intervention services to Aboriginal people and communities in Central Australia.

Central Land Council:

The Central Land Council is a Commonwealth statutory authority established under the *Aboriginal Land Rights (Northern Territory) Act 1976* and a Native Title Representative Body under the *Native Title Act 1993*.

The CLC is one of four Northern Territory Land Councils. The CLC region covers the entire southern half of the Northern Territory, an area of some 780,000 square kilometres of land. The council is made up of 90 Aboriginal people from more than 15 language groups elected from communities across the region.

The CLC is first and foremost a representative organisation for the Aboriginal people in its region particularly on land related matters, including land claims and economic use of land.

NAAJA:

NAAJA delivers quality and culturally appropriate Aboriginal legal services to the Top End of the Northern Territory in criminal law, family law, civil law as well as advocacy and community legal education.

Northern Land Council:

The Northern Land Council processes outstanding land claims under the *Aboriginal Land Rights (Northern Territory) Act 1976*, as well as undertaking responsibilities under other legislation, such as native title claims. In addition, assisting landowners with land management and economic development is now a priority. Many Aboriginal people use the Northern Land Council to assist them in "caring for country" and to develop economic opportunities. The Northern Land Council region covers the northern part of the mainland Northern Territory.

2 Executive Summary

APO NT believes that a holistic view of the factors underlying disadvantage and developmental delay in Aboriginal children is required before any actions can be taken to address the prevalence of FASD in communities.

This submission identifies ways in which the Government can address Aboriginal and Torres Strait Islander disadvantage in an inclusive and culturally appropriate way using evidence based research. "Closing the Gap" in the NT will never be achievable until genuine partnership with Aboriginal people is a priority of the state and federal Governments.

The Closing the Gap Clearing House report, *What works to overcome Indigenous disadvantage* found that what does work is community involvement and engagement; adequate resourcing and planned and comprehensive responses; respect for language and culture; development of social capital; recognising underlying social determinants; commitment to doing projects with, not for, Aboriginal people; creative collaboration; and understanding that issues are complex and contextual.

It found that what doesn't work includes "one size fits all" approaches and a lack of collaboration with communities.

Addressing the determinants of mental health within Aboriginal communities

Any genuine approach to prevent and address FASD within Aboriginal communities must include evidence based approaches to addressing these determinants of mental health. APO NT believes that strategies to address the broader structural and social determinants of health must accompany strategies to address the ill effects of alcohol consumption.

Supply reduction measures have been shown to be the most powerful intervention to reduce alcohol consumption and also to greatly contribute to a reduction in associated child abuse.[1] APO NT believes that an introduction of a floor price and regulating outlet density are two key measures that need to be prioritised as public health measures for addressing alcohol misuse.

The role of primary health care in reducing the prevalence and impact of FASD

This submission demonstrates that the most realistic way to reduce harm from alcohol consumption in pregnancy through clinical service delivery is through an integrated approach within comprehensive primary health care. Aboriginal community control health services (ACCHS) provide a range of clinical services that are relevant to the prevention of FASD and the early detection and management of children with FASD. These include screening for hazardous drinking in regular health checks and opportunistically; high quality antenatal care (with screening for alcohol use and tobacco); and universal childhood surveillance. The critical elements of a primary health care response to FASD are outlined below.

[1] Scott D, 2008.

Social and emotional well being services integrated into primary health care

ACCHSs are leaders in clinical governance and provide the strongest models of comprehensive primary health care service delivery in Australia.[2] The community controlled sector recognises the high need for holistic social and emotional well being services to be incorporated within primary health care service delivery. Within the AMSANT model (Appendix 2) there is a strong preventative approach delivered by Aboriginal family support workers who can work with their communities and community controlled boards to provide leadership and reduce harm from alcohol and other drugs. APO NT believes that ongoing support and development of services in line with this model, represents a culturally appropriate, evidence based and cost effective approach to addressing the many health and social consequences of alcohol and other drug misuse, including FASD.

The Olds model of nurse home visitation

The Olds model of nurse home visitation and case management of children from vulnerable families provides structured support for women in pregnancy until the child is aged two. Provided to pregnant women in low socioeconomic neighborhoods for over twenty five years in the USA, the program has been shown to reduce alcohol and other drug use in the mother and child as well as improving outcomes for educational attainment for children, reduced rates of child neglect and abuse and reduced rates of juvenile offending for children.[3] The Olds program of home visitation is already being delivered as a pilot program by selected ACCHSs. AMSANT believes that it should be funded for all ACCHSs that are in a position to deliver the program.

Support for children with FASD and other disabilities in primary health care

All children with high needs due to factors such as physical illness, disability, developmental delay and/or family dysfunction require case management within primary health care. Some large ACCHSs provide case management of children with high needs, with care being provided by Aboriginal Health Workers, child nurses and social workers supported by visiting specialists such as pediatricians and specialist allied health providers. Many services

[2] Phillips et al, 2010.
[3] Olds et al, 1998; Olds et al, 1997.

are not funded to provide this type of multidisciplinary care. Given the extent of the need, all ACCHSs should be funded to provide case management for high risk children.

Educational day care: The Abecedarian program

The Abecedarian program is an out of home care model which demonstrates an enriched care approach for children with a range of disadvantages, including children with FASD. It has demonstrated long term sustainable benefits including educational and social outcomes which reach adulthood[4]. The Abecedarian program complements the Olds model of home visitation as parents who are not ready to address their substance misuse issues are unlikely to engage with or adopt the advice of the Olds Program.

Educational support

There is strong evidence and universal agreement of the fundamental importance of education in underpinning the future health, wellbeing and economic security of individuals, families and communities. This submission outlines a variety of improvements to the NT education system which would assist Aboriginal children to learn more effectively and to enjoy learning in a culturally appropriate way. Changes such as positive rather than negative messaging around parental responsibility and school attendance as well as ensuring a flexible curriculum that includes Aboriginal languages, cultures and history would assist any child with developmental delays to learn more effectively and enjoy school.

Diagnosis and Management – implications in the criminal justice system

APO NT maintains that there needs to be better resourcing of the criminal justice system to enable any person suspected of having developmental or cognitive impairments to be assessed and have access to appropriate case management that informs sentencing dispositions. As diagnosing FASD among children and adults is challenging, some will enter the criminal justice system without appropriate consideration of their impaired functioning by the court. This is exemplified by the lack of access to community services which may assist an individual with FASD, as magistrates could consider alternative and more appropriate sentencing options if they were available.

[4] McCormick et al, 2006; Mclaughlin et al, 2008' Barnet et al, 2007; Campbell et al, 2008

3 Recommendations

1. Approaches to FASD must be evidence-based but also developed in collaboration with communities so that they are flexible rather than a "one size fits all" approach.
2. There must be action on social determinants including employment housing and education if sustained progress is to be made on addressing FASD
3. Effective alcohol control measures should be introduced including a floor price and reduction in the density of liquor outlets

Primary health care

4. The following services should be funded in Aboriginal PHC services across the NT:

- Social and emotional well being services which address both alcohol and mental health issues should be funded in ACCHSs across the NT. This service should include a community development/prevention arm. (See Appendix 1).
- The Olds program of nurse family visitation should be provided to all services with capacity
- Case management of children with disability
- Targeted family support to families referred to the child protection system who do not require urgent statutory intervention but who require ongoing support

Education

5. Services to children with learning and other disabilities in Northern Territory schools must be improved
6. Urgent attention should be given to implementing the recommendations regarding early childhood and education in the Closing the Gap Clearinghouse report, *What works to overcome Indigenous disadvantage*
7. There must be urgent investment in increasing the capacity of schools in the remote NT to address the decades of under investment

8. The education system in the NT must be made more culturally appropriate including through a bilingual approach with appropriate engagement of the school with the community. This must include appropriate cultural education and mentoring for teachers.
9. Homelands Schools should be resourced as fully functioning schools

Criminal justice system

10. There must be appropriate multidisciplinary assessment services for children and adults in the criminal justice system to identify FASD or other developmental disabilities and their impact on defendant's behaviours. These services must be equipped to promptly prepare reports for the court that are reflective of the defendant's situation.
11. Appropriate and humane options must be developed for the care of individuals who experience intellectual disabilities or developmental conditions such as FASD to avoid sentences of imprisonment

4 Addressing the determinants of mental health within Aboriginal communities

As stated in *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*:

> *The co-morbidity of mental health and harmful substance use among Aboriginal people needs to be contextualized by the legacy of colonization, racism and marginalization from dominant social institutions. International and Australian research clearly demonstrates that health in general; mental health and substance misuse are affected by social and structural factors such as housing, education, employment, income, transport and access to supportive social networks. Until Aboriginal people are generally equal in terms of social indicators such as adequate housing, literacy levels, employment and income, the prevalence of harmful substance use and mental health problems among them is unlikely to decline.*[5]

Any genuine approach to prevent and address FASD within Aboriginal communities must include evidence based approaches to addressing these determinants of mental health. APO NT believes that stand alone strategies to address the ill effects of alcohol consumption, without being accompanied by strategies to address the broader structural and social determinants of health, will have limited effectiveness.

APO NT continues to lobby for regulatory measures to reduce supply (such as the reduction of liquor outlet density) and for price control (such as the implementation of a minimum floor price) as evidence-based strategies for effectively combating harm from alcohol, including foetal alcohol spectrum disorder. Such supply reduction measures have been shown to be the most powerful intervention to reduce alcohol consumption and also to greatly contribute to a reduction in associated child abuse.[6] APO NT believes that an introduction of a floor price and regulating outlet density are two key measures that need to be prioritised as public health measures for addressing alcohol misuse. Attached is AMSANTs alcohol control policy which has been endorsed by the AMSANT Board (Appendix 1).

[5] Wilkes, Gray, Saggers, Casey and Stearne, 2010, p.128
[6] Scott D, 2008.

5 FASD in Aboriginal communities in the NT

Diagnosis of the conditions that come under the general term FASD is complex.[7] Children with obvious features of FASD are relatively rare, FASD is often not well detected and the rate of FASD in remote communities is not known with any certainty.[8] However, there are alarmingly high levels of suboptimal physical, language and cognitive development in children in remote areas as evidenced by the recent Australian Early Development Index (AEDI) surveys.

There is a complex web of causative factors underlying these high rates of developmental vulnerability in Aboriginal children. These factors include anemia, malnutrition, frequent infections, poor parenting skills and lack of access to quality child care. Children whose mothers consume dangerous levels of alcohol during pregnancy, often continue to have their development compromised by ongoing alcohol and other drug issues within their family. The compromised development of children whose parents have alcohol and other drug issues is also often related to poverty, socio-economic factors and low educational attainment of parents and caregivers. Therefore APO NT believes that a holistic view of the factors underlying disadvantage and developmental delay in Aboriginal children is required.

6 Other preventative measures

APO NT supports warnings on alcoholic beverages. It is noted however that such warnings may have limited effect on a population with relatively low English literacy, as is the case with Aboriginal and Torres Strait Islanders in the NT. Social marketing campaigns in remote communities may be effective but should be designed in partnership with communities to ensure that they are appropriate.

7 The role of primary health care in reducing the prevalence and impact of FASD

7.1 The evidence base

[7] Peadon, O'Leary, Bower and Elliot, 2007
[8] Peadon et al, 2007

The evidence base for clinical and educational initiatives that work to reduce drinking in pregnancy is relatively weak.[9] APO NT believes that the most realistic way to reduce harm from alcohol consumption in pregnancy through clinical service delivery is through an integrated approach within comprehensive primary health care, using the relatively strong evidence base about what works to reduce alcohol consumption in the general population.

Aboriginal community controlled health services provide a range of clinical services that are relevant to the prevention of FASD and the early detection and management of children with FASD. These include:

- Screening for hazardous drinking in regular health checks and opportunistically.
- High quality antenatal care (with screening for alcohol use and tobacco).
- Universal childhood surveillance.

Relevant services that are available only in some ACCHSs (but should be available universally) include:

- Integrated social and emotional well being services.
- Multidisciplinary case management of children from vulnerable families.
- Intensive family support during pregnancy and up until the child is 2 as per the Olds model (discussed at 7.1.2 below).

7.1.1 Social and emotional well being services integrated into primary health care

Aboriginal community controlled services provide the strongest models of comprehensive primary health care service delivery in Australia and are leaders in clinical governance.[10] The community controlled sector recognises the high need for holistic social and emotional well being services to be incorporated within primary health care service delivery.

AMSANT has developed a model for integrating alcohol and other drugs, community mental health and primary health care in Aboriginal Medical Services in the Northern Territory, which has been endorsed by the AMSANT Board of Directors (Appendix 2). APO NT believes that ongoing support and development of services in line with this model, represents a culturally appropriate, evidence based and cost effective approach to addressing the many

[9] Stade et al., 2010.
[10] Phillips et al, 2010.

health and social consequences of alcohol and other drug misuse, including FASD. Primary health care is the only sector that can realistically undertake screening and early intervention for hazardous alcohol consumption as well as mental health problems in women of child bearing age. Women with significant problems can then be referred to skilled counselors working within primary health care. This is particularly pertinent to FASD given that a large proportion of pregnancies are unplanned and much of the damage from alcohol occurs in the early weeks of pregnancy when women frequently do not know they are pregnant.[11]

Delivering these services within a comprehensive primary health care framework makes them universally available for all women – enabling alcohol issues to be addressed prior to pregnancy in women of child-bearing age or during pregnancy. A survey of Australian women of childbearing age showed that women identified health professionals as the best source of information about alcohol use during pregnancy.[12] It is also recognised that in relation to addressing alcohol and drug misuse, pregnancy represents a significant opportunity for change for a woman, with the consideration of the health of her baby representing a powerful motivating factor.[13] Another strong advantage of this model is the provision of integrated alcohol and drug services with mental health services, as it is acknowledged that mental health issues often form the backdrop for alcohol and drug misuse.

Within the AMSANT model there is a strong preventative approach delivered by Aboriginal family support workers who can work with their communities and community controlled boards to provide leadership and reduce harm from alcohol and other drugs. These preventative, educational and community development approaches are very significant approaches to preventing FASD within communities. Aboriginal family support workers can be supported by provision of appropriate community education resources about drinking in pregnancy; but community based interventions will be much more powerful if they are localised.

The model also provides for referral pathways both within the organisation and with external agencies such as residential rehabilitation services.

[11] Peadon et al, 2007.
[12] Peadon, Payne, Bower, Elliott, Henley, D'Antoine et al., 2007.
[13] Alcohol and Pregnancy Project, TICHR, 2009.

Unfortunately many ACCHSs are not currently funded to deliver such services (including the majority of services in the NT) and there has been an increasing trend for alcohol and other drug services in Aboriginal communities to be awarded on the basis of competitive tendering which has led to a fragmentation of service delivery and weakening of Aboriginal governance and input into these services. This has led to suboptimal outcomes.

7.1.2 The Olds model of nurse home visitation

Other clinical services that are relevant to FASD include the Olds model of nurse home visitation and case management of children from vulnerable families. The Olds model provides structured support for women in pregnancy until the child is aged two. It has been provided to pregnant women in low socioeconomic neighborhoods for over twenty five years in the USA. The program has very strong evidence of improving outcomes for both mother and child in a range of areas including educational attainment for children, reduced rates of child neglect and abuse and reduced rates of juvenile offending for children.[14] The Olds program has also been shown to reduce alcohol and other drug use in both the mother and child.[15] The Olds program of home visitation is already being delivered as a pilot program by selected ACCHSs. AMSANT believes that it should be funded for all ACCHSs that are in a position to deliver the program, given the strong evidence of benefit.

7.1.3 Support to children with FASD

The AEDI survey demonstrated that children in remote Northern Territory have alarmingly high levels of delayed development or risk across the five areas of childhood development: physical health and well being; social competence; emotional maturity; language and cognitive skills (school based); communication skills and general knowledge. For instance, in the Barkly Region, over one quarter of children were at risk in the domain of language and cognition with one third scoring as being at risk in the area of physical health and well being.

Therefore, there are large numbers of children with disabilities in remote communities and some of these will have FASD or related disorders. All children with high needs due to factors such as physical illness, disability, developmental delay and/or family dysfunction require case management within primary health care. Some large ACCHSs provide case

[14] Olds et al, 1998; Olds et al, 1997.
[15] Olds et al, 1998.

management of children with high needs, with care being provided by Aboriginal health workers, child nurses and social workers supported by visiting specialists such as pediatricians and specialist allied health providers. Many services are not funded to provide this type of multidisciplinary care. Given the extent of the need, all ACCHSs should be funded to provide case management for high risk children.

Some regional NT ACCHSs are also funded to provide intensive family support to children who have been referred to child protection but who are not in need of urgent statutory intervention and so can be referred back to primary health care. This is working well and we believe that this model needs to be extended to all ACCHSs with the capacity to provide this service.

7.1.4 Educational day care: The Abecedarian program

APONT highlights the benefits of the enriched care giving approach of educational day care for children with a range of disadvantages, including children with FASD. The Abecedarian program has demonstrated long term sustainable benefits in educational and social outcomes which continue into adulthood[16]. It is also cost saving as it reduces adult smoking rates, increasing life time earning and reducing schooling costs for economically disadvantaged children.[17] The Abecedarian program complements the Olds model of home visitation as outlined below, as parents who are not ready to address their substance misuse issues are unlikely to engage with or adopt the advice of the Olds Program. The children of families who do not wish to engage with the Olds Program will benefit greatly from the additional stimulation provided by the out of home care. This type of day care is offered through the Abecedarian program and has been demonstrated to be of benefit to children irrespective of whether or not their parents address their substance misuse. APONT strongly believes that investment in a population level program like the Abercedarian Program for all disadvantaged children will address the needs of FASD children and will be of significantly greater benefit than an investment in a FASD targeted program.

[16] McCormick et al, 2006: Mclaughlin et al,2008,Barnet et al, 2007.Campbell et al,2008
[17] W.S. Barnett , Leonard N. Masse (2007)

7.1.5 Educational support

Children with FASD require educational support, which is beyond the scope of this submission. However, it is clear there is insufficient intensive learning support in remote communities given the findings from the AEDI survey.

There is strong evidence and universal agreement of the fundamental importance of education in underpinning the future health, wellbeing and economic security of individuals, families and communities.[18] APO NT identifies the following actions as necessary to improve the educational opportunities for children with FASD in the NT:

- Full consideration of the early childhood education and schooling findings of the Closing the Gap Clearinghouse report: *What works to overcome Indigenous disadvantage*.
- Positive rather than negative messaging around parental responsibility and school attendance.
- Ensuring schools have effective mechanisms for parental/family/community engagement
- Flexible curricula that include Aboriginal languages, cultures and history.
- More Aboriginal staff in schools
- Training in cross-cultural communication and engagement skills, cultural awareness and Aboriginal languages, cultures and histories for teachers.
- Additional investment in remote Aboriginal schools, including from the Australian Government, to redress historic under-investment and provide equitable resourcing of schools.
- All Homeland Learning Centres should be recognised as proper schools and resourced as such.
- Governments must develop a comprehensive plan for the provision of education to remote Aboriginal communities, including clear criteria for the ongoing provision and resourcing of schools.
- Governments should ensure comparable funding allocations to schools, including between government and non-government schools.

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- Consideration should be given to ongoing multiple areas of disadvantage faced by families, particularly in housing, in calibrating initiatives to engage parents and children in schooling.

8 Diagnosis and Management – implications in the criminal justice system

As stated at Part 5 above, FASD is not well detected either generally or specifically among young Aboriginal people in the Northern Territory. Diagnosing FASD among children and adults has historically presented doctors with a challenge. Cases of even full-blown foetal alcohol syndrome[19] often go undetected at birth and later in life.[20] Children with less severe anomalies typical in the FASD continuum present an even greater diagnostic challenge, because often the physical signs are more subtle.[21]

In the Northern Territory, one barrier to diagnosing FASD relates to the difficulties diagnosing pediatricians experience in confirming prenatal maternal alcohol use. This constitutes an essential criteria in diagnosing FASD, however is often not well-documented and doctors are unable to rely on hearsay evidence about alcohol consumption to make a diagnosis.[22]

Additionally, issues arise due to the absence of a multi-disciplinary team who can contribute to FASD diagnosis. Currently, FASD is primarily diagnosed in Central Australia by pediatricians, who generally work with children until a maximum age of fourteen. Intensive contact between pediatricians and young people ceases some time before adolescence. However, for those individuals who are at the lower end of the foetal alcohol spectrum, behavioural issues that may suggest FASD become more apparent as the young person becomes older and physically bigger, due to the more pronounced impact of their misbehavior. Often, these young people will fail to be diagnosed[23] however will intersect with the criminal justice system.

Case Study: A 15 year Aboriginal girl in the care of the NT Department of Children and Families (DCF) has a history of exhibiting difficult behaviour. As a result of her behaviour, she has been excluded from schooling for approximately five years. Over a period of 14

[19] Individuals at the severe end of the foetal alcohol spectrum.
[20] Little BB, Snell LM, Rosenfeld CR, Gilstrap LC III, Gant NF, 1990
[21] Astley SJ, Clarren SK, 2000
[22] Conversation with Rose Fahy, Head of Paediatrics at Alice Springs Hospital, 13 December 2011.
[23] Ibid.

months, the girl has become involved in offending, primarily property damage, which has brought her before the courts on several occasions. Due to the girl's behaviour and concerns about her well being, DCF was ordered to provide a report to the Court about the girl's family support and access, accommodation, education and developmental issues. While the report stated that it has been identified that the girl is operating intellectually as a seven year old, no formal FASD diagnosis was referred to and there was no proposed FASD management plan.

Without a formal medical diagnosis of FASD, it is difficult for magistrates to rely upon impaired functioning as a mitigating factor in sentencing. Moreover, the dearth of specific management services or a centre to coordinate access to community services that may assist an individual with FASD, provide few options for magistrates to effectively and creatively sentence offenders with FASD before the courts. Consequently, sentencing dispositions are rarely able to reflect the difficulties experienced by FASD affected individuals and instead offenders with FASD are subject to the same sentences and punishments, such as imprisonment, as fully functioning offenders, despite this being inappropriate. APO NT maintains that there needs to be better resourcing of the criminal justice system to enable any person suspected of having developmental or cognitive impairments to be assessed and have access to appropriate case management that informs sentencing dispositions.

Case Study: A 22 year old Aboriginal female who resided in Alice Springs had been diagnosed with Foetal Alcohol Syndrome. Despite this, the female has had repeated contact with the criminal justice system since 2008 and consequently experienced many periods of imprisonment. Magistrates in Alice Springs comment on the inappropriateness of imprisoning the woman but note the dearth of alternate options: *"The Northern Territory Government has chosen not to provide any services for people such as [X] ... The Northern Territory Government is well aware that there are people such as [X] in this community who need assistance, and they have chosen, at an executive level, to make a decision not to provide those services....I expect they're saying that the criminal justice system should be picking up and dealing with people who suffer as she suffers from an illness. In my opinion that's highly inappropriate ... There are ... few sentencing options available to this court ...*

There is nothing to be gained from giving consideration to specific deterrence, there is very little gained in giving consideration to ... rehabilitation."[24] The female was sentenced to a period of imprisonment.

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

[24]Mr G Borchers SM, 2009, *Police v RF*, Northern Territory Court of Summary Jurisdiction Alice Springs.

References

- Alcohol and Pregnancy Project. (2009) *Alcohol and Pregnancy: an Foetal Alcohol Spectrum Disorder: A Resource for Health Professionals* (1st revision). Perth: Telethon Institute for Child Health Research
- Astley SJ, Clarren SK. (2000) "Diagnosing the full spectrum of fetal alcohol-exposed individuals: introducing the 4-digit diagnostic code". *Alcohol Alcohol.* 35 :400– 410.
- Barnett WJ, Masse LN. (2007) "Comparative benefit–cost analysis of the Abecedarian program and its policy implications." *Economics of Education Review*. Volume 26, Issue 1, February 2007, Pages 113-125
- Campbell F, Ramsey, C. (2008). "Effects of Early Intervention on Intellectual and Academic Achievement: A Follow-up Study of Children from Low-Income Families." *Child Development.* 65(2). 684-698
- Little BB, Snell LM, Rosenfeld CR, Gilstrap LC III, Gant NF, (1990) "Failure to recognize fetal alcohol syndrome in newborn infants". *Am J Dis Child*.(1990);144 :1142– 1146.
- McLaughlin AE, Campbell FA, Pungello EP, Skinner M. (2007) "Depressive symptoms in young adults: the influences of the early home environment and early educational child care." *Child Dev.* May-Jun;78(3):746-56.
- McCormick MC, Brooks-Gunn J, Buka SL, Goldman J, Yu J, Salganik M, Scott DT, Bennett FC, Kay LL, Bernbaum JC, Bauer CR, Martin C, Woods ER, Martin A, Casey PH (2006).. "Early intervention in low birth weight premature infants: results at 18 years of age for the Infant Health and Development Program". *Pediatrics.* 2006 Mar;117(3):771-80.
- O'Donnell M., Scott D A., & Stanley, F, (2008) "Child Abuse and Neglect – is it time for a public health approach?" *Australian and NZ Journal of Public Health*, Vol 32, No. 4, pp 325-330.
- Olds, D, Eckenrold J, Henderson C et al (1997) "Long-term Effects of Home Visitation on Maternal Life Course and Child Abuse and Neglect". *JAMA.* . 278(8):637-643

- Olds, D, Henderson C, Cole R et al (1998): "Long-term Effects of Nurse Home Visitation on Children's Criminal and Antisocial Behavior. 15-Year Follow-up of a Randomized Controlled Trial". *JAMA* 280:14. P1238-1244.
- Olds, L. Charles R. Henderson, Jr., Harriet J. Kitzman John J. Eckenrode, Robert E. Cole, Robert C. Tatelbaum. (1998) "Prenatal and Infancy Home Visitation by Nurses:Recent Findings." *The future of children*. Spring/Summer edition
- Peadon, E., O'Leary C, Bower C and Elliot E. 2007. Alcohol use in pregnancy. "The role of the GP." Australian Family Physician
- Peadon E, Payne J, Bower C, Elliott E, Henley N, D'Antoine H et al. "Alcohol and pregnancy: Women's knowledge, attitudes and practice." *Journal of Paediatrics and Child Health*. 2007; 43(7-8): A12.
- Phillips C, Pearce C, Hall S, Travaglia J, Luisignan S, Love T and Kljakovic M (2010) "Can clinical governance deliver quality improvement in Australian general practice and primary care? A systematic review of the evidence." *MJA*: 193 . 602-607.
- Scott D (2008); "A public health model of child protection." *Australian Centre for Child protection*. University of South Australia
- Stade BC, Bailey C, Dzendoletas D, Sgro M, Dowswell T, Bennett D.2009. "Psychological and/or educational interventions for reducing alcohol consumption in pregnant women and women planning pregnancy." *Cochrane Database Syst Rev*. Apr 15;(2):CD004228.
- Wilkes E, Gray D, Saggers S, Casey W and Stearne A. "Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice" In: Purdie N, Dudgeon and Walker R. (Eds). 2010. *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice.*