

# UnitingCare Australia

## Submission to the Closing the Gap Refresh

April 2018

### Preamble

UnitingCare Australia is the national body for the Uniting Church's network of community service providers, one of the largest in Australia. With over 1,600 sites, the network employs 40,000 staff and is supported by the work of over 30,000 volunteers. We provide services to children, young people and families, people with disabilities, the poor and disadvantaged, people from culturally diverse backgrounds and older Australians in urban, rural and remote communities. We also deliver services to Aboriginal and Torres Strait Islander communities across Australia and work with those communities to ensure that these services are integrated and responsive to need.

UnitingCare Australia works with and on behalf of the network to advocate for policies and programs that will improve people's quality of life. UnitingCare Australia is committed to speaking with and on behalf of those who are the most vulnerable and disadvantaged.

The views reflected in this submission are informed by expertise from within our network, including the Aboriginal and Torres Strait Islanders Peoples within our services.

### Introduction

UnitingCare Australia supports the Government's stated desire to take action to improve the lives of Aboriginal and Torres Strait Islander peoples. However, we consider that the seven Closing the Gap targets and the strategies adopted to pursue them are not sufficiently ambitious to tackle the breadth and depth of disadvantage and discrimination faced by Aboriginal and Torres Strait Islander peoples. Further targets are needed to cover the multitude of related risk factors that interact to raise the prevalence of unsatisfactory outcomes across the existing target measures and on many additional measures that should be added to these targets.

To achieve significant improvements, a range of upstream conditions that affect health, behaviour, and social, emotional and spiritual well-being would need to be addressed. Sir Michael Marmot refers to these upstream conditions as 'the causes of the causes'<sup>1</sup>.

Indicators for these conditions need to be developed and assessments of their prevalence amongst Aboriginal and Torres Strait Islander peoples need to be made. The policies that will achieve real gain for the next generation will focus on primary prevention, that is on preventing the harms caused by conditions that can themselves be prevented. There is ample evidence on which to base these policies. Following is a list of recommendations following by more detail of the considerations on which they are based.

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<sup>1</sup> See, for example, Boyer Lecture, "[Health inequality and the causes of the causes](#)", 16 September 2016.

### **Recommendations:**

1. Measure progress in implementing the Declaration on the Rights of Indigenous Peoples
2. Identify the 'causes of the causes' – the social and economic determinants of health
3. Measure the incidence of prenatal risk factors
4. Measure the incidence of early childhood risk factors
5. Measure the incidence of risk factors for child maltreatment
6. Adopt policies of primary prevention: where exposure to risk factors can be humanly prevented - prevent it! Where it cannot be prevented intervene early with evidence based remediation
7. Measure the extent of discrimination and take measures to address it
8. Measure the extent to which the developmental needs of Aboriginal and Torres Strait Islander children are being met
9. Support for the recommendations of Aboriginal and Torres Strait Islander Peak Bodies
10. Measure the extent to which the conditions for meaningful and sustained employment for Aboriginal and Torres Strait Islander peoples have been created

### **1. Measure progress in implementing the Declaration on the Rights of Indigenous Peoples**

The Declaration of the Rights of Indigenous Peoples (the Declaration) was developed after extensive deliberations by Indigenous Peoples themselves. It represents the conditions that they need to live a healthy and meaningful life.

Although all the rights recognised in the Declaration are important, two are fundamental for the improvement of the health and well-being of Aboriginal and Torres Strait Islander peoples, as they concern agency: Article 3, the Right to Self-Determination, and Article 10, the Right to free, prior and informed consent in relation to the adoption and implementation of any legislation or administrative measures that may affect them. Implementation of these rights would mean that Aboriginal and Torres Strait Islander peoples must be empowered to lead their own model of development.

The importance of Declaration rights is reflected in the *Special Gathering Statement, Closing the Gap Refresh: Building Pathways for future prosperity* (the Statement) which demands from government: 'a community led, strength based strategy that enables us to move beyond surviving to thriving.' The Statement notes that most progress toward the targets has occurred in those programs that have been designed and implemented by Aboriginal and Torres Strait Islander communities. It calls on the Government to negotiate further targets with those communities and their representative bodies.

Although implementation of the Declaration would address many of the ‘causes of the causes’ discussed below, it would also serve the critically important purpose of acknowledging the status of Aboriginal and Torres Strait Islander peoples in their own Country. This is particularly important given the history of colonisation, of dispossession, of refusing to recognise Aboriginal and Torres Strait Islander peoples’ common humanity, and of treating with contempt their culture, languages, sacred values and spiritual association with Country that gave rise to the world’s longest continuous culture.

## **2. Identify the ‘causes of the causes’ – the social and economic determinants of health**

When distinguished Australian epidemiologist Sir Michael Marmot speaks of ‘the causes of the causes’ in relation to health status he is referring to:

the social determinants of health: the conditions in which people are born, grow, live, work and age [and] inequities in power, money and resources that give rise to inequities in the conditions of daily life.

Health and inequalities in health are closely linked to the conditions in which we raise our children, the education we get, the neighbourhoods in which we live, the work we do, whether we have the money to make ends meet, our social relationships, our care for the elderly. In short, all the things that matter to us day to day and in the arc of our lives influence health. And these conditions of life that matter to us are strongly influenced by the decisions that societies make and, indeed, global decisions that influence our social environment.<sup>2</sup>

These upstream causes are identifiable through large scale, longitudinal research, rather than the correlational research that is useful in identifying associations between, for example, behaviour, ‘lifestyle’ or health care access, and morbidity and mortality.

...you might be thinking, the poor probably don’t look after themselves and when, inevitably, they get sick won’t or can’t get access to medical care.

On the first, life style, let me summarise by saying that smoking, drinking, unhealthy patterns of eating and exercising, and obesity are indeed causes of ill-health. But we have to address ‘causes of the causes’. Why in Australia, as elsewhere, are smoking and obesity more common the lower one is in the social hierarchy – people with lower income and education are more likely to smoke, or be overweight than people with more income and education. The causes of the causes are the social determinants of health and they influence not only life style but stress at work and at home, the environment, housing, transport.<sup>3</sup>

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<sup>2</sup> Ibid.

<sup>3</sup> Ibid.

The social gradient that is evident in the health and well-being of all Australians reflects the inverse relationship between social and economic advantage and problem outcomes. As long as Aboriginal and Torres Strait Islander children, adults, families and communities remain the most disadvantaged in Australia, they will continue to be characterised by the highest concentration of outcomes that reflect this disadvantage. As Sir Michael Marmot says:

The link between deprivation of social conditions, ill-health and crime is all too obvious in Australia. The life expectancy gap between the Indigenous and non-Indigenous populations of Australia is about 11 years. It had been said to be 17 years. Whether it's actually got smaller or it's a change in the calculation -either way it's enormous. Australian Aborigine (sic) men are six times more likely, and Aboriginal women eleven times more likely, to die of ischaemic heart disease than non-Indigenous men and women. The diabetes, the differences are more alarming. The diabetes death rate is nineteen times higher in Aboriginal men, and twenty-seven times higher in Aboriginal women, than in the non-Indigenous population.

Incarceration rates, too, fit with the pattern of ill-health and crime clustering together. Aborigines make up 2.5 per cent of Australia's population and 25 per cent of the prison population. Some of that appalling excess will be higher crime rates, linked to deprivation, and some will be discrimination through all parts of the justice system.<sup>4</sup>

### 3. Measure the incidence of prenatal risk factors

Research supporting the Developmental Origins of Health and Disease<sup>5</sup> (originally known as the Barker Hypothesis) illustrates the importance of establishing 'eudaemonic'<sup>6</sup> conditions from conception onwards in order to optimise health status throughout life.

Here are some of the gestational conditions that can compromise developmental health:

- Infections and use of antibiotics
- Stress<sup>7</sup> and the experience of domestic violence;
- Under-nutrition<sup>8</sup>;
- Exposure to environmental toxins<sup>9</sup> and
- Cigarette smoke, alcohol or other drugs can compromise development<sup>10</sup>

<sup>4</sup> Ibid.

<sup>5</sup> See for example this material for UNSW Medical Students: [Abnormal Development - Developmental Origins of Health and Disease](#), March 2018.

<sup>6</sup> Promoting human flourishing.

<sup>7</sup> Mulder et al. (2002) [Prenatal maternal stress: effects on pregnancy and the \(unborn\) child](#). *Early Human Development* Volume 70, Issues 1–2, December 2002, Pages 3-14

<sup>8</sup> Heijmans et al (2008) [Persistent epigenetic differences associated with prenatal exposure to famine in humans](#) *PNAS*, November 4, vol. 105, no. 44: 17046–17049

<sup>9</sup> Bommarito P et al [Effects of prenatal exposure to endocrine disruptors and toxic metals on the fetal epigenome](#). *Epigenomics*. 2017 Mar;9(3):333-350. doi: 10.2217/epi-2016-0112.

<sup>10</sup> Thomson et al. [Prenatal exposure to drugs: effects on brain development and implications for policy and education](#) *Nat Rev Neurosci*. 2009 Apr; 10(4): 303–312. doi: [10.1038/nrn2598](#)

However, conditions experienced by parents prior to conception can also affect their offspring. For example:

- adversity in the early life of the mother can affect the development of her children.<sup>11</sup>
- paternal smoking, drinking and exposure to environmental toxins can affect child development.<sup>12</sup>
- Maternal and paternal obesity can affect development in early childhood.<sup>13</sup>

To the extent that Aboriginal and Torres Strait Islander families continue to live in conditions that have led to poorer health and well-being prior to parenthood, as well as to increased stresses, poorer health and nutrition, higher levels of smoking, drinking and drug use, and higher exposure to family violence during pregnancy, their children will continue to suffer higher incidence of developmental problems from the beginning of life. To prevent these problems, it is necessary to identify and address the ‘causes of the causes.’

#### 4. Measure the incidence of early childhood risk factors

Research has revealed that the experience of adversity is biologically embedded<sup>14</sup> and the cumulative experience of adversity from conception across the early years of childhood can exert harmful effects over a lifetime. The latter can be seen, *inter alia*, in physiological systems and brain structure and function that are poorly adapted to cope with stress,<sup>15</sup> in changes in the levels of inflammation that may predispose individuals to later disease,<sup>16</sup> in changes in gene expression (epigenetic changes) that affect lifetime vulnerability to problems with physical health, mental health, learning, and behaviour.<sup>17</sup> The impact of adversity is determined by its timing, duration, intensity, cumulative risk exposure, as well as the sex and the genetic, and epigenetic susceptibility of the individual.<sup>18</sup>

Adversity-linked epigenetic changes may even be transmitted across generations who have not themselves been exposed to adversity.<sup>19</sup>

<sup>11</sup> Toepfer P et al (2017) [Oxytocin Pathways in the Intergenerational Transmission of Maternal Early Life Stress](#) *Neurosci Biobehav Rev.* 2017 Feb; 73: 293–308, and

<sup>12</sup> Alok Jha [Drink and drugs can damage men's sperm, study suggests](#) *Guardian* 19 February 2008

Soubry et al [A paternal environmental legacy: Evidence for epigenetic inheritance through the male germ line](#) *Bioessays* 36: 359–371, 2014 DOI 10.1002/bies.201300113

<sup>13</sup> Yeung E et al. [Parental Obesity and Early Childhood Development](#). *Pediatrics*. 2017;139(2)

<sup>14</sup> Herzmann C [Putting the concept of biological embedding in historical perspective](#). *Proc Natl Acad Sci U S A.* 2012 Oct 16; 109(Suppl 2): 17160–17167. doi: [10.1073/pnas.1202203109](#)

Berens A et al (2017) [Biological embedding of childhood adversity: from physiological mechanisms to clinical implications](#). *BMC Med.* 2017; 15: 135. doi: [10.1186/s12916-017-0895-4](#)

<sup>15</sup> McEwen B [Brain on stress: How the social environment gets under the skin](#). *PNAS* October 16, 2012. 109 (Supplement 2) 17180–17185; [https://doi.org/10.1073/pnas.1121254109](#)

McEwen B et al [Recognizing resilience: Learning from the effects of stress on the brain](#) *Neurobiology of Stress* Volume 1, January 2015, Pages 1-11 [https://doi.org/10.1016/j.ynstr.2014.09.001](#)

<sup>16</sup> Ehrlich K et al [Testing the biological embedding hypothesis: Is early life adversity associated with a later proinflammatory phenotype?](#) *Development and Psychopathology* 28 (2016), 1273–1283doi:10.1017/S0954579416000845

<sup>17</sup> Sokolowski M & Boyce T [Epigenetic embedding of early life adversity and developmental risk](#) *Encyclopedia of Early Childhood Development*, November 2017.

<sup>18</sup> Ibid.

<sup>19</sup> Scorza et al (2018) [Research Review: Intergenerational transmission of disadvantage: epigenetics and parents' childhoods as the first exposure](#) *The Journal of Child Psychology and Psychiatry*; Aiken C & Ozanne S (2014) [Transgenerational developmental programming](#) *Human Reproduction Update*, Volume 20, Issue 1, 1 January 2014, Pages 63–75, [https://doi.org/10.1093/humupd/dmt043](#)

Some risk factors, such as maltreatment (see section 5 below) are well known, others are not. They include: parental mental health problems; poverty and financial stress; unemployment; housing stress (more than 2 people per bedroom); housing insecurity (frequent moves); teen parent(s); low parental education (particularly maternal); more than 3 siblings; siblings born less than 2 years apart; low birthweight; short or no breast-feeding etc.<sup>20</sup>

When the exposure to risk factors is taken into account, there is no significant difference in the performance of Aboriginal and Torres Strait Islander children and their peers on measures of cognitive and non-cognitive development in the first year of school.<sup>21</sup>

Preventing or at least minimising exposure to known risk factors will provide a solid foundation for healthy development and learning.

## **5. Measure the incidence of risk factors for child maltreatment**

Child maltreatment – which includes physical, emotional and sexual abuse as well as neglect – is the single most influential known cause of lifetime mental health impairment that is preventable (the other high-impact causes being primarily genetic), with conservative estimates of prevalence of about 15% in high-income countries.<sup>22</sup>

The consequences of maltreatment in a particular case depend on its timing, duration, and intensity, as well as on the sex and genetic vulnerability of the victim. However, the population cost is predictably high.

In Australia the lifetime economic costs of child maltreatment have been estimated at \$9.3 billion and the lifetime costs in terms of reduced quality of life and premature mortality at \$17.4 billion.<sup>23</sup>

A recent (conservative) estimate of average lifetime economic costs to the individual victim of child maltreatment by a primary carer in the UK was £89,390. The largest components of this came from the costs of social care, short-term health-related costs, and the costs resulting from a lower probability of employment.<sup>24</sup>

Constantino<sup>25</sup> estimated that maltreatment accounts for at least 25% of the population-attributable risk for child psychopathology. In a survey for the WHO Kessler et al (2010)<sup>26</sup> reported that childhood adversities accounted for 28.9% of adult psychopathology in a range of high, middle and low-income countries.

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<sup>20</sup> For a list of risk factors and sources of evidence see pp 16-22 of Biddle & Seth-Purdie (2013) [Relationship between development risk and participation in early childhood education: How can we reach the most vulnerable children?](#)

<sup>21</sup> Op. Cit.

<sup>22</sup> Constantino J (2018) [Prevention of child maltreatment: strategic targeting of a curvilinear relationship between adversity and psychiatric impairment](#) *World Psychiatry*17:1 - February 2018.

<sup>23</sup> McCarthy M et al (2016) ) [The lifetime economic and social costs of child maltreatment in Australia](#) *Children and Youth Services Review* v. 71 Dec 2016: 217-226.

<sup>24</sup> Conti et al (2017) [The economic cost of child maltreatment in the UK. Preliminary study estimating the lifetime costs of child abuse and neglect](#) National Society for the Prevention of Cruelty to Children (NSPCC), UK. The authors gave the 95% confidence limits as £44,896 and £145, 508.

<sup>25</sup> Constantino J (2018) [Prevention of child maltreatment: strategic targeting of a curvilinear relationship between adversity and psychiatric impairment](#) *World Psychiatry*17:1 - February 2018.

<sup>26</sup> Kessler et al (2010) [Childhood adversities and adult psychopathologies in the WHO World Mental Health Surveys](#) *Br J Psychiatry*. 2010 Nov; 197(5): 378–385.doi: 10.1192/bjp.bp.110.080499

### *Risk factors for maltreatment*

- Child born as a result of unintended and unwanted pregnancy – whether the pregnancy was unwanted by either father or mother.<sup>27</sup>
- Economic disadvantage accounts for an estimated 27.3% of maltreatment, with poverty and parental unemployment the strongest predictors (Australian data).<sup>28</sup>
- Poor parental mental health, parental substance abuse, and social instability (as well as higher levels of economic disadvantage) were strongly associated with increased risk of child maltreatment. Nine independent factors were identified in an Australian data set - the risk of maltreatment increased exponentially as risk factors accumulated, and exceeded 80% in the highest risk groups (Australian data).<sup>29</sup>
- Parental experience of abuse in childhood
  - After adjustment for other risk factors, a maternal history of either unsubstantiated (hazard ratio = 2.19, 95% confidence interval: 2.06, 2.33) or substantiated (hazard ratio = 3.19, 95% confidence interval: 3.00, 3.39) maltreatment emerged as a strong predictor of maltreatment and CPS involvement in the next generation (US data).<sup>30</sup>
- Parental experience of out of home care.
  - Almost one-third of children and young people involved with the NSW statutory child protection system in 2014–15 had at least one parent who had either been reported or were in OOHC when they were a child. The intergenerational link was strongest for children and young people in OOHC with almost one-half having a parent who had either been reported or were in OOHC when they were a child.<sup>31</sup>
- Exposure to Intimate Partner Violence (IPV). Exposure to IPV constitutes maltreatment even in the absence of other forms of maltreatment.<sup>32</sup> Exposure to IPV in the family (US data) was 'very closely associated with several forms of maltreatment and exposure to other forms of family violence [...] with adjusted OR<sup>33</sup> ranging from 3.88 to 9.15.'<sup>34</sup>

The increased prevalence of these factors in Aboriginal and Torres Strait Islander families highlights once again the urgent need for primary prevention policies below.

<sup>27</sup> Guterman K (2015) [Unintended pregnancy as a predictor of child maltreatment](#). *Child Abuse Negl.* 2015 Oct;48:160-9. doi: 10.1016/j.chiabu.2015.05.014.

<sup>28</sup> Doidge et al (2017) [Economic predictors of child maltreatment in an Australian population-based birth cohort](#). *Children and Youth Services Review* V. 72, January 2017, pp 14-25

<sup>29</sup> Doidge et al (2017) [Risk factors for child maltreatment in an Australian population-based birth cohort](#). *Child Abuse Negl.* 2017 Feb;64:47-60. doi: 10.1016/j.chiabu.2016.12.002.

<sup>30</sup> Putnam-Hornsten et al (2015) [A Population-Level and Longitudinal Study of Adolescent Mothers and Intergenerational Maltreatment](#). *American Journal of Epidemiology*, Volume 181, Issue 7, 1 April 2015, Pages 496–503, <https://doi.org/10.1093/aje/kwu321>

<sup>31</sup> [The prevalence of intergenerational links in child protection and out-of-home care in NSW](#). FACSAR Report, August 2017.

<sup>32</sup> See for example Wathen CN & MacMillan H (2013) [Children's exposure to intimate partner violence: Impacts and interventions](#). *Paediatr Child Health.* 2013 Oct; 18(8): 419–422.

<sup>33</sup> OR – Odds Ratio – or hazard ratio.

<sup>34</sup> Hamby et al (2010) [The overlap of witnessing partner violence with child maltreatment and other victimizations in a nationally representative survey of youth](#). *Child Abuse Negl.* 2010 Oct;34(10):734-41. doi: 10.1016/j.chiabu.2010.03.001.

**6. Adopt policies of primary prevention: where exposure to risk factors can be humanly prevented - prevent it! Where it cannot be prevented intervene early with evidence based remediation**

*Policies to prevent maltreatment*

A public health approach aimed at reducing the prevalence of risk factors, and providing support for families in high risk categories, would be expected to reduce the incidence of harm and reduce the need for child removal.

Constantino sums up the evidence concerning risk, how it might be ascertained and how it might be addressed:

Our ability to predict child maltreatment on the basis of risk indicators that can be feasibly ascertained on the first day of an infant's life (including indices of parental mental health or substance use impairment, concentrated poverty, and a range of socio-economic stress indicators) has considerably advanced, and specific risk profiles can be delineated identifying a subgroup of children who have an up to 70% likelihood of ultimately being detected in official governmental records for child abuse/neglect. In spite of this, hospitals and health agencies rarely systematically screen for child maltreatment risk.

Child maltreatment is preventable. Its prevention requires the coordinated application of interventions that address key lapses in "species-typical" mechanisms of protection of the young: caregiving knowledge and competence, resource acquisition, surrogacy (i.e., the family or adult "village" surrounding a child to assist when a parent needs help), and close surveillance of the child.

A prototypic, yet remarkably common risk scenario is that of a single parent with multiple young children, isolated by poverty, under-educated in the modelling of appropriate caregiving (or whose own experience in being parented was traumatic or deficient) and with either an untreated mental health impairment or substance use disorder.

An effective, evidence-informed approach to reduce the risk of child maltreatment imposed by this set of circumstances would include nurse (or paraprofessional) home visitation, parenting education, parental mental health care, a support resource for times of crisis, and reproductive health planning. This is analogous to the level of comprehensive intervention that is afforded to patients with complex medical disorders in most health systems, encompassing cost-efficient, evidence-based interventions that could be prioritized for families at risk and coordinated by efficient, targeted case management.<sup>35</sup>

The suffering of so many maltreated Aboriginal and Torres Strait Islander children is preventable, just as the suffering endured by so many of their parents was preventable. We need to stop the intergenerational transfer of maltreatment by taking note of the relevant risk factors and limiting exposure to them or mitigating their impact.

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<sup>35</sup> Constantino J (2018) [Prevention of child maltreatment: strategic targeting of a curvilinear relationship between adversity and psychiatric impairment](#) *World Psychiatry*17:1 - February 2018.

## **7. Measure the extent of discrimination and take measures to address it.**

The experience of racial discrimination affects Aboriginal and Torres Strait Island families and has a measurable impact on the developmental health of their children. Shepherd et al (2017) estimated that 16.2% of the Population Attributable Risk (PAR) for mental health problems amongst 5-10-year-old children could be attributed to the experience of racial discrimination, with 19.1%, 8.2%, and 13.2% of PARs for sleep difficulties, obesity and asthma, respectively.<sup>36</sup>

## **8. Measure the extent to which the developmental needs of Aboriginal and Torres Strait Islander children are being met**

Parents need to understand and have the means to meet the all the developmental needs of their children. These needs include secure attachment, authoritative discipline, freedom from exposure to family violence, a home environment that promotes learning, nutrition that promotes growth and supports good mental health, positive engagement with the cultural life of their community, including development of their Language and care for their Country.

## **9. Support for the recommendations of Aboriginal and Torres Strait Islander Peak Bodies**

As Aboriginal and Torres Strait Islander representative bodies have pointed out, the intentions of Close the Gap as it was originally envisaged have not been fulfilled, funding of programs has been substantially cut, support for Aboriginal and Torres Strait Islander owned and operated health facilities has been undermined, and there has been substantial underinvestment in prevention and early intervention.

We support their call for justice targets – the high and growing over representation of Aboriginal and Torres Strait Islander peoples in juvenile detention and adult prisons reflects the failure to address the conditions that increase the risk of involvement in the criminal justice system. We support the call for an examination of discrimination in access to diversionary and rehabilitation programs that reduce the use of custodial sentences, which should always be used as a last resort.

We support their call for justice reinvestment as useful strategy for diverting resources from the expensive, counterproductive and too frequently cruel system of detention and imprisonment towards activities capable of rehabilitating, healing and reintegrating.

And we support the call for increased self-determination in the implementation of programs – as called for in the Declaration the Statement.

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<sup>36</sup> Shepherd et al (2017) [The impact of racial discrimination on the health of Australian Indigenous children aged 5–10 years: analysis of national longitudinal data](https://doi.org/10.1186/s12939-017-0612-0) *International Journal for Equity in Health* 2017;16:116 <https://doi.org/10.1186/s12939-017-0612-0>

**10. Measure the extent to which the conditions for meaningful and sustained employment for Aboriginal and Torres Strait Islander peoples have been created**

Noting the widening rate of unemployment between Indigenous and non-Indigenous people, we posit that greater attention to the health and wellbeing measures advocated in this submission would substantially contribute towards creating the conditions for sustained and meaningful employment for Aboriginal and Torres Strait Islander communities. In addition, we advocate initiatives to be developed and delivered by Aboriginal and Torres Strait Islander organisations and communities and supported by the Federal Government, that generate employment opportunity and facilitate job creation. This would improve performance against the existing employment target as well as contributing to individual, family and community health and wellbeing.

We highlight the role for Government in enabling employment opportunity through both demand- and supply-side policies to improve the job readiness of Aboriginal and Torres Strait Islander peoples, as well as to stimulate local economies and increase employment opportunities. We refer to our recommendations forwarded to the Senate Selection Committee's Inquiry on the Future of Work and Workers for further consideration<sup>37</sup>.

**Conclusion**

UnitingCare Australia is supportive of the Government's desire to take action to improve the lives of Aboriginal and Torres Strait Islander peoples through the refresh of the Closing the Gap initiative. We would be pleased to provide further information on the issues and recommendations to this process which are raised in this submission.

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<sup>37</sup>See UnitingCare Australia's submission to the Senate Select Committee's Inquiry into the *Future of Work and Workers*, available at: <https://www.aph.gov.au/DocumentStore.ashx?id=a50352d6-866c-462d-8222-77f6cc09e3d3&subId=563757>