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UNDERSTANDING THE NEXUS BETWEEN ALCOHOL CONSUMPTION, SOCIAL AND EMOTIONAL WELL-BEING, AND HIGHER EDUCATION OUTCOMES AMONG ABORIGINAL AND TORRES STRAIT ISLANDER MALES IN AUSTRALIA

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Abstract

Education is a critical social determinant of health, particularly in the context of Aboriginal and Torres Strait Islander health and well-being. There is also a broad array of other health risk factors that intersect with these social and cultural determinants of health. Overall, an in-depth examination of the complex health–education nexus is needed. This paper provides a commentary on interrelationships between health risk factors, their impact on education trajectories, and their implications for Aboriginal and Torres Strait Islander males.

Keywords: Aboriginal and Torres Strait Islander people; alcohol; education; male health; social and emotional well-being

BACKGROUND

In 2012, an independent expert panel released Australia's first ever national review of higher education access and outcomes for Aboriginal and Torres Strait Islander people.[1] This review, alongside more recent reviews into regional and remote education, conveyed that Aboriginal and Torres Strait Islander people have lower rates of higher education participation, completion, and achievement than their non-Indigenous counterparts.[1–4] These observations, and subsequent recommendations arising from these reports, have consistently conveyed calls for action to improve higher education access, trajectories, and outcomes for Aboriginal and Torres Strait Islander people.[5] Furthermore, the Australian National Aboriginal Education Policy advocated for the need to close the

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gap in achievement and completion rates between Aboriginal and Torres Strait Islander and non-Indigenous Australians.[5,6]With concurrent advocacy efforts by the National Aboriginal and Torres Strait Islander Higher Education Consortium (NATSIHEC), there have been successive targeted investments in Aboriginal and Torres Strait Islander higher education policy and program development in Australia over the past few years.[7–9] This has included programs such as the Indigenous Student Success Program (ISSP) and the broader equity-focused Higher Education Participation and Partnership Program.[8,10] In addition, commissioned research has been conducted aimed at exploring ways to accelerate Aboriginal and Torres Strait Islander higher education outcomes.[11]Consequently, a range of explanatory frameworks, actions, and solutions have emerged which aim to respond to the ongoing impacts of colonization, racism, intergenerational trauma,[12] insufficient resourcing, and the lack of culturally responsive education environments and curricula.[11] We are particularly interested in the additional social and cultural dimensions in this paper. We argue, as have other men's health scholars,[13–15] that gendered dimensions need to be understood in tandem with broader social and cultural dimensions, such as age, race, ethnicity, sexuality, geography, and socioeconomic status. That is, they are all intimately intertwined. While there is evidence of investment in increasing Aboriginal and Torres Strait Islander female participation in science, technology, engineering, and mathematics (STEM),[11] Aboriginal and Torres Strait Islander males are underrepresented in higher education, compared to Aboriginal and Torres Strait Islander females.[1] As Stahl et al.[16, p. 1] argue:

The enrolment, participation and completion rates of Indigenous males in higher education remains a major concern in Australia today. While Indigenous males have reasonable rates of participation in Vocational Education and Training, they are far less likely to engage in university than Indigenous females.[16]Other recent higher education scholarship has reinforced similar concerns.[17–19] We argue that understanding the multiple dimensions that impact on Aboriginal and Torres Strait Islander male participation in higher education is important. This includes a deeper understanding of the nexus between health and education outcomes. This paper aims, in part, to address this gap using an intersectional framework.

INTERSECTIONALITY

Intersectionality is one way to explore the nexus between culture and gender in higher education, and to also unravel the inter-relationship between health and education attitudes, behaviors, and outcomes. Intersectionality can be broadly defined as an analytic and theoretical approach that considers the meaning and consequences of socially defined constructs and the complex causality of social phenomena, particularly where issues of equity are concerned.[15]The term "intersectionality" originated in the late 1980s in the American context[20]; however, it is deeply embedded beyond American history. According to Hankivsky:Intersectionality promotes an understanding of human beings as shaped by the interaction of different social locations (e.g., 'race'/ethnicity, Indigeneity, gender, class, sexuality, geography, age, disability/ability, migration status, religion). These interactions occur within a context of connected systems and structures of power (e.g., laws, policies, state governments and other political and economic unions, religious institutions, media). Through such processes, interdependent forms of privilege and oppression shaped by colonialism, imperialism, racism, homophobia, ableism and patriarchy are created.[21, p. 2]Christensen and Jensen[22] describe intersectionality, in the context of male studies, as something that interplays with old and new concepts of masculinity, and different hegemonies.[22]Intersectionality has been used extensively as an explanatory framework in health and higher education research relating to African-American men,[13,23–26] but less so with Aboriginal and Torres Strait Islander males.[27] However, we consider intersectionality as a potentially useful tool for understanding, researching, promoting, and enacting ways for Aboriginal and Torres Strait Islander males. Recent health-related scholarship has explained that:Aboriginal and Torres Strait Islander males conceptualize and negotiate health from both Western and Aboriginal paradigms and are constantly resisting and embracing different constructions of masculinity—sometimes simultaneously.[27, p. 162]There is emerging evidence from Australia to suggest that

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similar complex inter-relationships occur in Aboriginal and Torres Strait Islander higher education contexts.[16] However, this is currently limited to a single case study,[16] and further research is urgently required.Intersections between different facets of life—including individual, family, and community influences and the respective social systems they embody—and how they influence identity formation among Aboriginal and Torres Strait Islander males need to be better understood. We know that these intersections impact Aboriginal and Torres Strait Islander male health, including education attitudes, behaviors, and outcomes, but we are less sure about what factors have the greatest influence, and why.

DECOLONIZING THE CONVERSATION

In a broader sociopolitical context, there has been recent work undertaken relating to the achievement of social and political justice for Aboriginal and Torres Strait Islander people in Australia. This is exemplified through the Uluru Statement from the Heart (The Statement).[28] The Statement is a signed document formed and ratified by the delegates of the First Nations National Constitutional Convention.[28] The Statement calls for constitutional and legislative change, through a Voice to Parliament for Aboriginal and Torres Strait Islander people, the provision for making multiple treaties with governments, and a truth and justice commission, in order to ensure a process of healing and respectful intercultural dialogue through successive generations. The Statement is becoming increasingly important in an educational perspective, as it is a new movement and requires intergenerational understanding, and enhancement of its terms, in order for the momentum to grow. It has received support from multiple sectors and people from all areas of Australian society—media, business, law, government, and education.

While the Uluru convention and the key statements to emerge from this national meeting advocate macro socio-political changes for how the settler-colonial state functions in Australia, we believe that such changes will have the most significant impact at the micro-economic level where individual Aboriginal and Torres Strait Islanders might be liberated from a life of unemployment and welfare dependency and empowered by the right to labor.[28, p. 7]Embracing the philosophy of The Statement would mean that Aboriginal and Torres Strait Islander males, who have been routinely exploited by an industrialized capital, will be able to have localized control over their own lives, through the extension of self-governance at a community level. The importance of autonomy, self-control, and self-determination has been a prominent feature of health and education scholarship relating to Aboriginal and Torres Strait Islander people.[29,30]The inability of the education system to allow Aboriginal and Torres Strait Islander people to achieve self-determination in relation to education pathways remains problematic. We argue this has had a significant impact on opportunities for Aboriginal and Torres Strait Islander males to pursue higher education. To fully understand the barriers to higher education for Aboriginal and Torres Strait Islander males, it is useful, therefore, to understand the education trajectories across the life-course, including participation in early childhood education, primary school, and secondary school systems.

EDUCATIONAL ATTAINMENT AMONG ABORIGINAL AND TORRES STRAIT ISLANDER MALES

We acknowledge that Aboriginal and Torres Strait Islander people and Indigenous peoples in other countries can be as ethnically and racially diverse as they are similar. We also acknowledge that there are similarities between people of color more broadly based on their shared experiences as settler societies. While we are cautious in making comparisons between Indigenous and African-American populations, it is important to highlight that much can be learned from scholarship about race and culture that has emanated from the United States.[27,31] Indeed, emerging evidence about the intersections between health and higher education outcomes for people of color, and the subsequent implications for health promotion action, is worthy of acknowledgement, and has adaptation potential for Aboriginal and Torres Strait Islander males.There exists a significant gap in academic achievement between Indigenous and non-Indigenous students in countries with a history of European settlement. For example, there is a significant educational attainment gap between

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young boys and men of color and their Caucasian counterparts in the United States[32,33] and Canada.[34] International scholarship indicates that while there are significant gaps between Indigenous students and their non-Indigenous counterparts, there is a disparity in academic achievement between Indigenous male and female students.[34–36] For instance, in the United States, while male African-American students are excessively overrepresented in almost every category of academic underachievement, they are underrepresented in higher education courses.[32,37,38]Likewise, in Australia, there is a significant disparity in educational achievement and attainment between Aboriginal and Torres Strait Islander students and their non-Indigenous counterparts.[35] While Aboriginal and Torres Strait Islander children are less likely to participate in early childhood education, they are more likely to be absent from school on a given day and achieve lower levels of literacy and numeracy.[39] Furthermore, Aboriginal and Torres Strait Islander females have higher high school participation rates than their male counterparts (15 years old: 89% vs 86%; 16 years old: 68% vs 71%).[40] The corresponding rates are much higher for both non-Indigenous boys and girls, compared with their Aboriginal and Torres Strait Islander counterparts (boys: 96 and 87%; girls: 97 and 90%).[40] Similar trends were observed for higher education attainment (bachelor's degree or higher), with rates being higher for Aboriginal and Torres Strait Islander females, compared with males (6% vs 4%).[17]Early disengagement from education among men has a strong association with high rates of unemployment, incarceration, and homelessness.[41–43] Global evidence suggests that educational interventions aimed at reducing disengagement and attrition from school and higher education can have a positive impact on the health and well-being of young males,[44] particularly those from Aboriginal and Torres Strait Islander, and African-American backgrounds.[26,45]While education is frequently considered to be a critical social determinant of health, particularly within the context of Aboriginal and Torres Strait Islander health and well-being, there are also a broad array of other health risk factors (such as risky alcohol consumption, and poor social and emotional well-being) that intersect with these social and cultural determinants of health. That is, the health–education nexus is a complex space where interrelationships between different health risk factors, and their impact on education trajectories, need to be examined more closely. We start to examine these relationships below.

UNDERSTANDING THE HEALTH AND WELL-BEING DIMENSIONS OF ABORIGINAL AND TORRES STRAIT ISLANDER PARTICIPATION AND ACHIEVEMENT IN HIGHER EDUCATION

As stated above, there are multiple dimensions of Aboriginal and Torres Strait Islander health and well-being that influence participation and achievement in higher education. There is an interrelationship between health and education, where improved education outcomes can support improved health outcomes, and vice-versa. These are felt differentially by males and females, and influenced by other factors such as age, geography, and socioeconomic status.[26] However, this complex nexus between health and education is seldom addressed, and thus this is an important area for further research and practical action.[46] We hypothesize that a dual focus on the health–education nexus in practice and policy contexts will produce more pronounced and longitudinal impacts on the economic participation, employment, and leadership potential for Aboriginal and Torres Strait Islander peoples and communities.

There is scant Australian literature that has focused on health risk factors that influence participation and achievement of Aboriginal and Torres Strait Islander people in higher education.[47,48] And, that which does exist shows a relationship between alcohol consumption, social and emotional well-being, and higher education participation.[47–49] Other health risk factors that influence higher education outcomes might also exist. However, in light of limited evidence, our aim was to bring together fragmented scholarship to examine the emerging evidence-base relating to selected health and well-being dimensions likely to influence participation and achievement in higher education—namely alcohol consumption, and social and emotional well-being. We specifically aim to discuss these dimensions with respect to the health and education implications for Aboriginal and Torres Strait Islander males.

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Alcohol consumption

There have been significant declines in the proportion of Aboriginal and Torres Strait Islander people aged 15 years and above, consuming alcohol that exceeds lifetime risk guidelines.[50] However, higher rates of risky alcohol consumption (defined as consuming more than four standard drinks in one sitting) have been reported among this group compared to non-Aboriginal Australians (30% vs 25%),[50] with risky drinking behaviors especially pronounced among young undergraduate men.[49,51] Furthermore, the negative impacts on health and social outcomes attributable to risky drinking have been more pronounced among Aboriginal and Torres Strait Islander peoples compared with their non-Indigenous counterparts.[47,52] Noteworthy, higher rates of risky drinking and associated impacts have been reported for Aboriginal and Torres Strait Islander males when compared with their female counterparts (40% vs 21%).[47]International scholarship provides some evidence of an association between adolescent alcohol consumption and educational attainment; however, the evidence is not equivocal. Some studies have found a linkage between adolescent alcohol use and low school commitment, years in education,[53] and academic failure.[54] Others have found early alcohol use to be associated with lower school grades, especially among African-American students[55] and future educational achievement,[56] particularly for males.[57]Interestingly, an inverse relationship has been identified between alcohol use and educational attainment, in Australia. Higher education students are less likely to exceed the guidelines for both short-term and lifetime risk of harm from alcohol consumption compared with those who have not attained higher education.[58] For example, people aged 18–60 years who had completed a Certificate III or Certificate IV reported consuming alcohol at harmful levels than those with a bachelor's degree (major cities: 38% vs 26%; regional and remote areas: 42% vs 29%).[47] However, these data are not available by Indigenous status. On the other hand, there exist some data on the relationship between alcohol use and levels of schooling among Aboriginal and Torres Strait Islander peoples. For example, Aboriginal and Torres Strait Islander people aged 15–34 years who had completed Year 12 are less likely to be engaged in long-term risky drinking than those who had completed Year 9 or below (17% vs 22%).[48] These data, however, are not available by sex.

Silins et al.[59] identified significant associations between increasing frequency of alcohol use and lower educational attainment, through the integration of data from three longitudinal studies from Australia and New Zealand.[59] These findings showed 1.33–2.03 times higher odds of high school noncompletion, university nonenrollment, and degree nonattainment for weekly drinkers compared with those who had never used alcohol. Furthermore, temporal associations were identified across all outcomes, with effects strongest for weekly users.[59] The findings were not reported by participants' Indigenous status.

The unavailability of data on higher education and alcohol consumption (and other health risk factors/behaviors) among Aboriginal and Torres Strait Islander people constitutes an important gap in the literature. As a result, this impacts our understanding of the intersectionality between health risk factors and higher educational attainment among Aboriginal and Torres Strait Islander peoples. In saying this, the available data and the abovementioned findings set an important discourse about the potential links between alcohol consumption and higher education participation and achievement, and suggest that higher education may act as a protective factor in reducing high-risk patterns of alcohol consumption. Therefore, efforts to reduce harmful patterns of alcohol consumption may increase the potential to promote pathways and participation in higher education. Furthermore, other social factors are linked to increased alcohol use and ultimately impact higher education outcomes. These include individuals' (and parents' in case of children) low socioeconomic status,[59] parents' low education level,[59] remoteness,[47] Indigeneity (higher rates of abstinence but also higher rates of risky drinking have been reported among Aboriginal and Torres Strait Islander peoples),[50,60] poor mental health,[54,59] and parental and peer factors (e.g., family conflict).[54,59]Aboriginal and Torres Strait Islander people experience disadvantage on all abovementioned indicators when compared with non-Indigenous Australians,[61] with respective health and social inequities more evident among Aboriginal and Torres Strait Islander males.[47,62] Hence, a multifaceted

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health promotion and prevention approach tailored to suit Aboriginal and Torres Strait Islander males is crucial to address these factors, with significant potential to achieve a dual benefit of decreasing harmful alcohol use and increasing higher education participation and achievement outcomes.[54,59,63]For the health sector, this could mean more assertively promoting the educational and employment benefits of staying strong and healthy to young Aboriginal and Torres Strait Islander males. This could include health education that occurs through schools, sports clubs, and other social settings. Heath education programs should include the acknowledgment and promotion of protective factors such as sustaining strong connections and relationships with friends and family; avoiding risky health practices (such as drinking); and developing coping mechanisms to deal with stressful events. For the higher education sector, this could mean embedding an explicit focus on strategies that are likely to support the optimal health and well-being of university students during the delivery of outreach, pre-tertiary, and tutoring programs targeting young Aboriginal and Torres Strait Islander males. Emerging evidence with African-American males would suggest that the inclusion of peers and family members in such programs will achieve better outcomes.[26]

Social and emotional well-being

Prior to European settlement, Aboriginal and Torres Strait Islander societies provided the optimal conditions for mental health and social and emotional well-being.[64] Following European contact, these conditions have been continuously eroded, with notably high rates of mental health conditions among Aboriginal and Torres Strait Islander people when compared with their non-Aboriginal counterparts.[62] For example, 19% of the disease burden among Aboriginal and Torres Strait Islander people comprises mental health and substance-use disorders.[65] Factors that have contributed to adverse mental health conditions among Aboriginal and Torres Strait Islander people included intergenerational trauma manifested through both interpersonal and institutional racism, stress, prejudice and discrimination, lower socioeconomic status, and higher incarceration rates.[66] These factors are more prominent in Aboriginal and Torres Strait Islander males. For example, the suicide rate for Aboriginal and Torres Strait Islander people was twice that for non-Indigenous people between 2001 and 2010, with young Aboriginal and Torres Strait Islander males being most at risk (3.4 and 5.1 times as likely than non-Indigenous males aged 20–24 years and 25–29 years, respectively).[60] These adverse mental health factors have contributed to lower education attainment among Aboriginal and Torres Strait Islander peoples[48]; especially males.[41]A growing body of research suggests a correlation between education and poor mental health.[41,59] However, there exists limited research into establishing a causal link between the two. The available research suggests that there are mediating factors, such as employment, that are likely to affect this relationship.[48] As such, there have been calls for a sharper focus on addressing the social determinants that impact on the social and emotional well-being of Aboriginal and Torres Strait Islander people.[67] This includes a recognition of the impact of trauma, racism, unemployment, incarceration, educational attainment, poverty, and social and geographical isolation. Interestingly, many of these determinants of health also reflect those determinants of higher education identified by NATSIHEC at the beginning of this article. This reinforces the need to examine the intersectionality between the health and higher education nexus in greater detail and its contribution toward improving the health–higher education outcomes among Aboriginal and Torres Strait Islander males.Many Aboriginal Community Controlled Health Organizations have been attempting to address these concerns through the planning and delivery of social and emotional well-being programs and services that are built from, and resonate with, Aboriginal and Torres Strait Islander knowledge systems tied to concepts of kinship, country, and cultural identity.[68,69] Program responses have increasingly involved a strengths-based approach focusing on community connectedness, strengthening the individual and family, as well as culturally based programs.[70] However, there are only a few programs that are specifically designed for Aboriginal and Torres Strait Islander males. For example, the Family Wellbeing Empowerment Program (FWB) enables people to develop greater awareness of their

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emotional, spiritual, mental, and physical needs, and to strengthen personal and community capacity to meet these rights. The FWB was adapted for use among young Aboriginal and Torres Strait Islander males at risk.[71]

CONCLUSION

The relationships between health–higher education nexus, and the associated potential co-benefits, have not yet been fully examined specifically among Aboriginal and Torres Strait Islander males in Australia, or more broadly among Indigenous males globally. Thus, this is an important area for further research and practical action. Multifaceted, gender-specific, age-appropriate, and culturally responsive interventions are required to improve the intersecting health and education outcomes among Aboriginal and Torres Strait Islander males so as to address these concerns. Collaborative and participatory research approaches, consistent with decolonizing and Indigenist research methods, would be most appropriate.[12,72] We contend that an approach that acknowledges and responds to these inter-relationships is more likely to improve both higher education and health outcomes for Aboriginal and Torres Strait Islander males over the longer term when compared to a single sector or a single-issue strategy. We also hypothesize that a dual focus on the health–education nexus will produce more pronounced and longitudinal impacts on the economic participation and employment opportunities for Aboriginal and Torres Strait Islander people and the communities in which they live.

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