VICTORIAN ALCOHOL & DRUG ASSOCIATION

Submission
Yoorrook Justice Commission Issues Paper on Health

The Alcohol and Other Drug (AOD) system and First Peoples in Victoria

February 2024

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VAADA Vision

A Victorian community in which the harms associated with drug use are reduced and general health and well being is promoted.

VAADA Objectives

To provide leadership, representation, advocacy and information to the alcohol and other drug and related sectors.

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About the Victorian Alcohol & Drug Association

The Victorian Alcohol & Drug Association (VAADA) is a member based peak body representing organisations that support people who have alcohol and other drug (AOD) needs in Victoria. We work to prevent and reduce AOD related harms in the Victorian community by ensuring the people experiencing those harms, and the organisations that support them, are well represented in policy design, program development and public discussion.

We do this by

- Engaging in policy development
- Advocating for systemic change
- Speaking on issues identified by our members
- Providing system leadership
- Creating space for professional collaboration in the AOD sector
- Maximising opportunities to build professional capacity and capability
- Keeping our members and stakeholders informed about issues relevant to AOD; and
- Supporting evidence-based practice that reduces AOD related harms and maintains the dignity of those who use AOD (and related) services.

Acknowledgement of Country

VAADA acknowledges First Peoples as the traditional owners of the land on which we reside and work. We pay respect to Elders past and present and acknowledge that First Peoples have never ceded sovereignty to country. VAADA supports Voice, Truth and Treaty.

Please note that this submission contains references including the names of Aboriginal and Torres Strait Islander people who have died.

Special thanks to Mark Thomson and Kylie Lee for their assistance in preparing this submission.

Foreword

VAADA is pleased to make this submission to the Yoorrook Justice Commission in response to its Health Issues Paper.

Alcohol and other drugs is a major disease burden experienced by First Peoples in Australia, a consequence of the continuing impacts of colonisation and a response to trauma.

The Victorian AOD sector, including Aboriginal community controlled AOD services, have an important role to play in supporting the healing of First Peoples. Developing a health system that is culturally responsive and Aboriginal led and informed is essential.

VAADA hopes that this submission to Yoorrook provides ideas on what a re-imagined approach to AOD servicing looks like, building on the historic and ongoing leadership of First Peoples to provide solutions to health issues grounded in culture, country and community.

This submission has been informed by a review of the policy context and VAADA's knowledge of the AOD system, by our organisational members, and most importantly by members from the Aboriginal community in Victoria who have generously shared their experiences of what works, what needs improvement and what is not working in addressing AOD harm.

The Yoorrook Justice Commission is critical to determining what Treaty for Victoria must include. We thank the Commissioners for their work in leading Australia's first truth and justice commission. VAADA hopes that your bravery in taking on this challenge, leads to recommendations that support lasting change to address injustice and inequity, and forges a new path for all Victorians to be safe, well and strong.

Chris Christoforou
Chief Executive Officer

How this submission is structured

This submission is informed via three components:

Part One: A rapid literature review of evidence on First Nations AOD experiences and their interactions with the AOD service system.

Part Two: Consultation with VAADA member organisations to gauge the accessibility of services and their cultural safety for First Nations clients, their families and communities, and for Aboriginal staff working in the Victorian AOD sector.

Part Three: Interviews with six First Nations people working in Victoria's AOD service system. All stories were collected and prepared by Aboriginal consultant Mark Thomson (Wurundjeri and Yorta Yorta).

We hope this submission will lay the groundwork for talking about the AOD harms experienced by First Nations Peoples in Victoria, as a consequence of colonisation and that its recommendations support prevention, treatment and healing.

Definitions

The Yoorrook Justice Commission uses the term 'First Peoples' to refer to 'the traditional owners of the lands currently known as the State of Victoria, over which they maintain that their sovereignty was never ceded'.[1] This submission uses the terms First Peoples, First Nations and First Nations Peoples to refer to both the First Peoples of Victoria as well as Aboriginal and Torres Strait Islander People from Nations outside of Victoria who live and/or access AOD services in Victoria.

[1] Yoorrook Justice Commission (2021) *Letters Patent*, Government of Victoria.

Part One: Overview

1. Introduction

The Victorian AOD sector is comprised of a range of agencies, community health services and consortia who deliver a defined set of services and treatment types. Each year, Victoria's AOD treatment and support system helps around 40,000 people who are dependent on alcohol or other drugs.[2] Approximately 10% of these identify as Aboriginal and Torres Strait Islander (First Nations).[3] AOD services for First Nations People are provided by a range of services including Aboriginal Community Controlled Health Organisations (ACCHOs), generalist AOD agencies, public hospitals and private AOD providers.

It is important to situate AOD use among First Peoples within a social and historical context of colonisation, dispossession of land and culture, genocidal policies, racism, and social and economic exclusion.[4] This traumatic context has led to First Nations Australians experiencing a greater proportion of AOD-related harms. While some non-Aboriginal treatment providers have dedicated First Nations AOD programs and employ Aboriginal staff, First Nations Australians have generally been poorly serviced by the systems designed to address and ameliorate AOD-related harms.

A 2023 VAADA workforce survey of 396 AOD professionals indicated that only 1.3% identified as Aboriginal. While it is noted that ACCHOs providing AOD treatments were under-represented in this survey, the data suggests that there approximately 1.2 First Nations AOD workers for every 1,000 First Nations clients in Victoria, indicating a lack of cultural capacity to respond to treatment demand in Victoria.

Today, to support delivery of accessible, safe and appropriate AOD care, cultural safety training is available to improve the capacity of generalist services to provide culturally safe services and treatment. However, cultural safety training is not mandatory, nor is it covered in the Alcohol and Other Drugs Skill Set (the minimum qualification to work in the Victorian AOD sector).[5] Despite such initiatives, it is important to acknowledge that the Victorian AOD sector is founded on settler-colonial understandings of health, wellbeing, harm, and of First Nations peoples themselves, and that these influences continue to hold sway. This is despite an understanding and commitment from Victoria's

[2] The 40,000 comes from a 2022 audit of the Victorian Alcohol and Drug Collection dataset. It is an estimate based on intake at state-funded AOD providers (accessible here).
[3] The estimate of 10% First Nations clients in figure comes from the state-breakdown in an AIHW report on AOD treatment services (accessible here).
[4] Gray et al (2018) 'Review of the harmful use of alcohol among Aboriginal and Torres Strait Islander people', *Australian Indigenous Health*InfoNet.
[5] The AOD Skill Set is a nationally recognised qualification for working in AOD service provision. It was released in 2015 and has not been updated since then.

AOD service providers to provide culturally safe, high-quality and accessible care to First Nations Peoples, as well as a commitment to justice and self-determination for First Nations People. (See Part Two of this submission)

VAADA's submission has sought to capture reflections from First Nations Peoples and AOD service providers to support the Yoorrook Justice Commission's Inquiry into Health, assisting in the truth-telling process, by providing insights into the historical and ongoing injustices that impact First Nations People recovering from the harms of AOD.

The candid and powerful reflections of First Nations People who contributed to this submission provided first-hand experience of how the Victorian AOD system lacks flexibility to respond to the needs of First Nations clients. Interviewees pointed to, "rules that don't meet cultural needs" and "tight policies and procedures that don't work for our mob". While mainstream services have an important role to play, sometimes where Aboriginal clients purposefully seek an alternative to community controlled services, there are too few Aboriginal staff. As one respondent noted: "from my perspective, the biggest impact we have is when we have Aboriginal staff supporting patients." Others identified a lack of Aboriginal representation in mainstream leadership roles, contributing to a significant cultural load that Aboriginal staff carry. A lack of dedicated cultural supervision in the AOD sector only compounds this.

The interviewees also highlighted the long waiting times to access treatment and a lack of support on leaving services – increasing both vulnerability and risk for clients. One of the reasons for this is a lack of dedicated Aboriginal AOD services, both rehabilitation beds and withdrawal beds across the state. "We need a detox, we need two detoxes. It would take pressure off the mainstream services. We could do it culturally safe…we've got none, so why can't we have two? And we will do it our way."

Interviewees also emphasised the importance of rapport and relationship building between mainstream and Aboriginal AOD services ("the relationships between mainstream and community services needs to be strengthened"), and between government departments and Aboriginal AOD services. Yet, this building of trust and accumulation of knowledge about First Nation's needs among departmental staff is repeatedly disrupted by a constant movement of staff: "every six months you're dealing with someone else". Interviewees suggested creating pathways for public servants to engage in placements at ACCOs would go some way to building trust, knowledge and experience of Aboriginal AOD treatment. "Those people at the top might need to come and sit down and talk people down the bottom".

Above all, the embedding of culture in treatment services was identified as critical to wellbeing, psychological safety, treatment retention and treatment outcomes. Connection to culture builds resilience and healing: “we want service that's also going to meet our cultural needs, because they're as important as our physical needs are, being met.”

VAADA acknowledges and thanks interviewees for sharing their stories. Beyond the insights and understandings they offer, they highlight the importance of continuing to collect stories relating to the historic and ongoing injustices experienced by First Peoples in Victoria.

2. Background: A history of racism and stigma

Alcohol has long been a mechanism that settler-colonists have used to coerce, control, and exclude First Nations people throughout Australia's colonial history.[6] Accordingly, both the supply of alcohol and its restriction have been used to disempower First Nations Australians. [7] Stereotypes combining racism and AOD-related stigma (e.g. the 'drunken Aborigine') have been used to justify interventionist responses against Aboriginal people (often via rhetoric of 'protecting them from themselves').[8] The differential treatment of First Nations people who used AOD continued into the 20th century. For example, as mainstream AOD services moved away from abstinence-based AOD treatment modalities and adopted harm minimisation frameworks, abstinence remained the central aim for treatment provided to Aboriginal peoples.[9] Today, Western and settler-colonial understandings of First Nations Peoples' AOD use persist, from criminal justice to welfare policy and the provision of healthcare. For example, Uncle Larry Walsh, in his testimony to the Yoorrook Justice Commission described how, when he was taken to emergency with pancreatitis, hospital staff assumed the illness was due to alcoholism.[10]

In Victoria, structural inequalities faced by First Nations peoples who use AOD persist, evidenced by the disproportionate impact of AOD on First Nations Peoples and Communities. For example, Aboriginal peoples are over-represented in arrests for public drunkenness – representing 6.5% of arrests for public drunkenness arrests between 2014-19. [11] This tragically played out in the death of Aunty Tanya Day, which prompted the Victorian Government to introduce legislation decriminalising public intoxication, following an inquest that found laws prohibiting public intoxication disproportionately affected Aboriginal people and recommended their repeal.[12] This is in keeping with previous findings, including from the Royal Commission into Aboriginal Deaths in custody (1987-1991).

[6] Langton (1993) 'Rum, seduction and death: 'Aboriginality' and alcohol,' *Oceania*.
[7] Brady (2007) 'Equality and difference: persisting historical themes in health and alcohol policies affecting Indigenous Australians,' *Journey of Epidemiology and Community Health*.
[8] Langton (1993).
[9] Brady (2007).
[10] Uncle Larry Walsh (2022) 'Transcript of Day 1 – Wurrek Tyerrang Block 2', *Yoorrook Justice Commission.*
[11] *Seeing the clear light of day: Expert reference group on decriminalising public drunkenness: Report to the Victorian Attorney General* (2020), available here.
[12] See *Royal Commission into Aboriginal Deaths in Custody* (1991) Commonwealth of Australia.

Furthermore, the AOD care offered to First Nations peoples in the justice system is woefully inadequate. While data on the number of First Nations People who are in Victoria's prisons and also have an AOD issue is not available, research from New South Wales is indicative. An analysis of 1,132 adults in custody in NSW prisons found a significantly higher proportion of Aboriginal participants reported alcohol consumption consistent with dependence prior to prison entry as well as higher rates of substance dependence (general) and higher rates of cannabis, heroin and amphetamines use prior to entry, compared to non-Indigenous prisoners.

A recent cultural review of Victoria's adult prison system found:

> *Aboriginal people in custody… felt that appropriate alcohol and other drug (AOD) programs were not available to them, and that these programs are provided by staff and in locations that were not conducive to recovery in a culturally safe space.* [13]

Deaths in custody in the context of AOD use – such as Veronica Nelson, a Gunditjmara, Dja Dja Wurrung, Wiradjuri and Yorta Yorta woman, who died in custody in 2020 – are not isolated or uncommon. In 2022, Yorta Yorta and Gunnaikurnai man Joshua Kerr died while on remand in a Victorian prison having consumed methamphetamine, in full view of custodial and health staff.[14] Aunty Jill Gallagher, in her testimony to Yoorrook, addressed Aboriginal deaths in custody:

> *Alone, just this year, in 2022, we had five Aboriginal people die in custody in Victoria. Five Aboriginal people die in custody because they committed a crime of poverty. That's got to stop. Veronica Nelson – I will mention one of those deaths – Veronica died in 2020, a young Aboriginal woman. Her only crime was poverty. She got picked up for shoplifting. She was denied bail for shoplifting. She was denied bail twice for shoplifting. So, she went to Dame Phyllis [women's prison] and died… She died because she was poor because she couldn't get a job because she was a blackfella. The system needs to stop that… It comes from a racist punitive approach.*

Aunty Jill's testimony is a reminder that racism and stigma are very much alive today in Australia, and that they continue to have very real and profound consequences.

[13] Department of Justice and Community Safety (2023) *Cultural Review of the Adult Custodial Corrections System*, Victorian Government (accessed here).
[14] Sadler D. (2024, February 10-16), 'Inquest hears Indigenous man Joshua Kerr "died in full view of custodial and health staff",' *The Saturday Paper* (accessed here).

2.1. The complex legacy of alcohol and other drugs

Like many Australians, First Nations People use AOD for a range of reasons (enjoyment and fun, to feel connected to community, to escape worries or trauma, racism or other injustices).

While alcohol, for example, has caused significant harm to Aboriginal communities, it has also helped construct important spaces for culture and connection. As the late Uncle Jack Charles described in his evidence to the Yoorrook Justice Commission, it was in Fitzroy pubs where he first met his family, learnt where his mum lived, and connected to his culture and heritage.[15]For others, like the 'Parkies' of Fitzroy and Collingwood, drinking in public space represents pleasure, social and kinship connection, and 'feeling free'.[16]

A substantial body of research and first-hand evidence from First Nations Australians documents and recounts the way alcohol and other drug use and related policy responses have contributed to the systemic injustices faced by First Nations Australians (see Appendix i). However, this brief account provides important background and context for considering AOD-related harms faced by First Nations people in Victoria today, and how racism, stigma and colonial understandings continue to shape responses to AOD use among First Nations Victorians.

[15] Yoorrook justice Commission (2022) *Public Hearings: Elders' truth, 26 April to 6 May 2022*, accessed here.
[16] Savic et al (2021) 'Exploring the experiences and needs of people who drink in public spaces in the City of Yarra,' *Turning Point.*

3. AOD prevalence and harms among First Nations people

The empirical evidence on First Nations Australians' use of AOD is limited. There are multiple reasons for this, such as different data collection practices across states and territories. Data on AOD use among First Nations Peoples in Victoria remains inadequate and is contextualised by poor AOD data capability in the state generally.[17]

Despite these limitations, a review of existing data provides useful background and context for the first-hand accounts of First Nations people with lived experience of AOD and the service system.

3.1. Prevalence

According to the Australian Institute of Health and Welfare (AIHW), First Nations People represent 3% of the national population yet account for approximately 17.8% of clients in AOD services.[18] That is, First Nations People are nearly seven (7) times more likely to receive AOD treatment compared to non-Indigenous Australians. [19] In Victoria, First Nations Peoples represent 10% of clients in AOD services, but 1% of Victoria's population.[20]

Over-representation in treatment does not necessarily mean that First Nations Australians use AOD more than non-Indigenous Australians. Rates of alcohol abstinence, for example, are significantly higher among First Nations People compared to non-Indigenous Australians (29% of First Nations Australians vs. 14% for all Australians). [21] However, First Nations People who do drink are at significantly greater risk of alcohol-related harm.[22]

Victoria-specific data is less reliable owing to poor collection and management of AOD data. However, similar patterns and trends have been found. Research by the Kirby Institute in partnership with VACCHO found that young Aboriginal Victorians (16-29 years) used drugs at higher rates

[17] VAGO (2022) *Victoria's Alcohol and Other Treatment Data: Independent assurance report to Parliament*, Victorian Auditor General's Office, Victorian Government (accessible here).
[18] Heath et al (2021) 'Exploring the lived experiences of Indigenous Australians within the context of alcohol and other drugs treatment: A scoping review,' *Drug and Alcohol Review*.
[19] AIHW (2023) *Alcohol and Other Drug treatment Services National Minimum Data Set (Client demographics: age group, sex, Indigenous status 2013-14 to 2021-22)*, Australian Institute of Health and Welfare, Government of Australia.
[20] AIHW (2023) *Alcohol and other drug treatment services in Australia: Annual report (state and territory summaries: Victoria)*, Australian Institute of Health and Welfare, Government of Australia.
[21] AIHW (2019) *Alcohol, tobacco and other drugs in Australia*, Australian Institute of Health and Welfare, Australian Government.
[22] Krakouer et al (2022) 'Community-based models of alcohol and other drug supports for First Nations Peoples in Australia: A systematic review', *Drug and Alcohol Review*.

compared to their non-Aboriginal counterparts. Use of both cannabis (21% vs. 30%) and methamphetamine (5% vs. 9%) in the past 12 months was higher for young Aboriginal Victorians.[23]

3.2. Harms

AOD-related harms are difficult to measure. This is, in part, because there has been a longstanding focus on measuring prevalence of AOD use over harm. Furthermore, AOD-related harms can be wide-ranging, including acute and long-term health harms, impacts on mental health, lower quality of life, contact with the justice system, experiences of stigma and discrimination, relationship breakdown, child neglect, experiences of violence (as victim or perpetrator or both), and heightened risk of both suicide and transport accidents. Furthermore, data collection and coronial coding practices differ between the states and territories.

Despite these challenges, there is broad consensus, supported by evidence, that AOD is a key driver of the health disparities that exist between Indigenous and non-Indigenous Australians.[24]

In 2018, according to the AIHW, Mental Health and AOD accounted for nearly one quarter (23%) of the disease burden for Indigenous Australians (up from 13% in 2003). This is compared to 14% for all Australians. Alarmingly, a 2018 report by Australian Indigenous Health *InfoNet* found that, between 2011-2015, alcohol intoxication was indicated in 40% of Indigenous male suicides and 30% of Indigenous female suicides.[25]

Separating non-fatal from fatal disease burden reveals even starker results: mental health and AOD are the leading cause of non-fatal disease for First Nations Australians, representing 42% of non-fatal disease burden (compared to 24% for all Australians). This is nearly three times greater than the second leading cause – musculoskeletal conditions at 15%.

While the data presented above are limited and use non-Indigenous definitions and understandings of AOD and other concepts, they nonetheless provide important insights into the impacts of AOD on First Nations Australians. First Nations Peoples are over-represented in both prevalence and harms of AOD relative to their population size. First Nations Peoples who use alcohol or drugs are more likely to do so problematically, are more likely to experience harms relating to AOD-use and face additional barriers to accessing appropriate supports and services.

[23] Halacas et al (2015) '"Not everyone has that support": An evaluation of a series of harm reduction and AOD awareness activities within Victorian Aboriginal communities', VACCHO.
[24] Krakouer et al (2022).

It is worth noting that First Nations women and children bear a disproportionate share of harms associated with AOD and are acutely underserviced (Winja Ulupna is Victoria's only residential AOD treatment service of Aboriginal women which has only eight (8) beds). AOD-related domestic and family violence[26] and Fetal Alcohol Spectrum Disorder[27] occur at significantly higher rates among First Nations Australians.

[26] See Cripps (2023) *Indigenous domestic and family violence, mental health and suicide*, Australian Institute of Health and Welfare, Australian Government (accessed here).

[27] Data on prevalence of FASD is mixed. Some studies estimate FASD prevalence for Indigenous children at 2.76 per 1000 births (vs. 0.02 per 1000 births for non-Indigenous. However, FASD rates vary dramatically across the country – and rates in Victoria appear to be quite low (compared to other states and territories). In short, there are no national or Victorian estimates for FASD rates, though it is assumed cases are under-diagnosed. See AIFS (2015) Fetal alcohol spectrum disorders: a review of interventions for prevention and management in Indigenous communities,' Australian institute of Family Studies, Australian Government.

4. Alcohol and Drug Policy

Policy documents, in particular those relating to priority populations, can be impersonal and objectifying. For First Nations Australians, policy documents and strategies that present outcome measures of health and wellbeing, when overlaid by histories of trauma and exploitation, can perpetuate harmful colonial narratives and structural inequalities.

One study analysing a series of national policy documents (including data, strategy and report documents) on Indigenous AOD found the documents were culturally unsafe and decentered and objectified First Nations and homogenised AOD-related harms experienced by them. [28]

It is with this in mind that this submission will now review the policy context surrounding AOD use among Aboriginal peoples in Victoria.

4.1. First Nations AOD in Victoria

Currently, there is no active Aboriginal and Torres Strait Islander-specific drug strategy operating either in Victoria or nationally.

Nationally, the *National Aboriginal and Torres Strait Islander Peoples' Drug Strategy*, a sub-strategy of the *National Drug Strategy*, expired in 2019.[29] [30] This followed the de-funding of the National Indigenous Drug and Alcohol Committee (NIDAC) – which provided advice to government on AOD issues in Aboriginal and Torres Strait Islander communities – in 2014. Despite the lack of current AOD strategies or governance bodies for First Nations Australians at the national level, targets relating to First Nations alcohol and other drug use (including tobacco) are addressed in the national *Closing the Gap Agreement*.[31]

In Victoria, the *Koori Alcohol Action Plan* (KAAP) is a whole-of-government plan to reduce and prevent alcohol-related harms in Koori communities. It was developed as part of Victoria's commitment to the *Closing the Gap* agreement, recognising the role alcohol plays in contributing to the life expectancy gap.[32] It was developed in partnership with First Nations communities and the Victorian Aboriginal Community Controlled Health Organisation (VACCHO). While the KAAP did not address drug use other than alcohol, the plan recognised the complex, multi-faceted role of alcohol

[28] Gentile et al (2022) 'Much being Written about Us, not much being Written with US: Examining how alcohol and other drug use by indigenous Australians is portrayed in Australian Government policies and strategies: A discourse analysis', *International Journal of Drug Policy*.
[29] Intergovernmental Committee on Drugs (2014) *National Aboriginal and Torres Strait Islander Peoples' Drug Strategy 2014-2019*, Australian Government.
[30] Commonwealth of Australia (2017) *National Drug Strategy 2017-2026*, Australian Government.
[31] Commonwealth of Australia (2020) *National Agreement on Closing the Gap*, Australian Government.
[32] State Government of Victoria (2010) *Koori Alcohol Action Plan*, Victorian Government.

in First Nations communities, including contributions to domestic violence and suicide. The KAAP focused on supporting and empowering First Nations communities to reduce harms associated with alcohol, while also providing a centralised account of relevant strategies (i.e. mental health and health partnerships). The KAAP expired in 2020.

Without an overarching Victorian AOD Strategy, responses to AOD and associated harms among First Nations Peoples are spread across a range of plans, frameworks and legislation (state and federal) including both general and Aboriginal-specific documents. Victoria's *Ice Action Plan*,[33] for example, identifies Aboriginal services and clients as key stakeholders. *Koolin Balit: Victorian Government strategic directions for Aboriginal health*, which expired 2022 and has yet to be updated, also identifies AOD use among First Nations People as a priority area. The result is that there is no single repository for strategic direction on First Nations AOD, either in Victoria or nationally.

Despite the lack of a current strategy, there are other structures driving improved access to health services, including AOD, among First Nations Peoples in Victoria. For example, the *Aboriginal Health and Wellbeing Partnership Forum* is a collaborative partnership between the Aboriginal community-controlled health sector, mainstream health sector and Victorian Department of Health. The forum's purpose is to promote and pursue a shared vision of First Nations Victorians having access to a health system that is holistic, culturally safe, accessible and empowering. This is supported by the *Victorian Aboriginal Health and Wellbeing Partnership Agreement Action Plan 2023-2025* which aims to 'Support Alcohol and Other Drug service delivery' as a self-determined priority.

Furthermore, *Australian Indigenous Health InfoNet* is an online repository for policies, resources, programs and initiatives in Indigenous health, including AOD. Information, including service maps, are broken down by state and territory.[34]

Victorian AOD agencies also receive an additional 30% loading for services provided to Aboriginal clients, in recognition of different service needs and the increased complexities from bicultural care via Western-Anglo service models.[35]

While it is important for non-AOD specific strategies (for example, health strategies) to include both AOD and the unique needs and experiences of Aboriginal and Torres Strait Islander communities, the current lack of dedicated Indigenous AOD strategies nationally or in Victoria is noteworthy.

[33] State Government of Victoria (2015) *Ice Action Plan*, Victorian Government.
[34] *Australian Indigenous Health InfoNet* (accessed here).
[35] Department of Health, 'Funding of alcohol and other drug services', Victorian Government (accessed here)

4.2. Policy Context Recommendations

The development of a dedicated First Nations AOD Strategy in Victoria (ideally, as part of a broader Victorian AOD strategy) would improve strategic direction for the Department of Health, the AOD and Aboriginal community-controlled sectors, enhance strategic objectives with appropriate funding allocations, and provide a central framework for approved priorities, actions and directions for Aboriginal AOD service provision, supported by the establishment of an Aboriginal governance framework.

As a leading cause of disease in First Nations Australians, and the complex interrelation of AOD with mental health, suicide and family violence, it is also recommended that the establishment of a First Nations leadership and governance group to represent and advocate for First Nations empowerment, self-determination and self-management of AOD in Victoria be prioritised.

Recommendations:

4.2.1. The Victorian Government commit to establishing a Victorian Aboriginal Alcohol and Drug Strategy in consultation with VACCHO, First Nations communities and services, and other relevant stakeholders including VAADA.

4.2.2. In conjunction with 4.2.1, the Victorian Government, in consultation with VACCHO, establish a First Nations AOD governance and leadership group to support development, delivery and implementation of the strategy as well as to represent Victorian Aboriginal Drug and Alcohol services and support First Nations leadership and self-determination in AOD.

5. First Nations AOD service provision in Victoria

As of January 2024, there are 29 Aboriginal Community Controlled Organisations (ACCOS) funded to provide AOD-specific activities in Victoria. The range of services, treatments and supports offered by these organisations varies. Some, such as Bunjilwarra in Hastings, are highly specialised, providing culturally safe residential AOD treatment and healing to First Nations youth. Others, such as Dardi Munwurrow in Preston, specialise in working with First Nations clients who are in contact with the criminal justice system. Others still, offer a broad range of services (both AOD and general health and wellbeing), including outreach, intake and assessment, referral, counselling, and other non-residential programs and interventions.

In addition to this, Primary Health Networks (PHNs) – federally funded organisations coordinating primary healthcare across geographic areas – also fund delivery of AOD specific activities, including for First Nations Peoples.

Aboriginal-specific AOD programs are also offered by several mainstream AOD service providers and the Victorian government funds the placement of Aboriginal AOD workers in ACCOs across Victoria. These workers provide lower threshold AOD-related supports – such as assessment, counselling, care coordination, health promotion, group therapy, referral, and service liaison.

Further, a designated Aboriginal care and recovery coordination function is embedded within each Victorian catchment, to direct Aboriginal people seeking AOD treatment to appropriate services.

In addition to state and/or federally funded AOD supports and services, there exists an array of group-based treatment modalities such as Alcohol/Narcotics Anonymous. It is likely that First Nations Australians also engage with these supports but there is little to no data on this.

5.1. First Nations community-led models

The barriers First Nations People face include the systemic barriers such as long wait times and lack of geographic service coverage in regional areas that plague Victoria's AOD service system generally. However, there are also linguistic, cultural and logistical barriers specific to First Nations people.[36]

Responding to these barriers and their communities' needs, First Nations community led services (Aboriginal Community Controlled Health Organisations or ACCHOs) provide specialised AOD supports and treatment to First Nations clients. These include organisations explicitly funded to

[36] VACCHO (2015) '*Not everyone has that support*': An evaluation of a series of harm reduction and AOD awareness activities within Victorian Aboriginal Communities, Victorian Aboriginal Community Controlled Health Organisation.

provide AOD treatment to Indigenous clients such as Bunjilwarra in Hastings – as well as more generalist First Nations services – such as Ballarat and Distinct Aboriginal Cooperative, who are funded to deliver specific AOD activities among other supports and services. Beyond that, anecdotal evidence suggests that many Aboriginal Community Controlled Organisations (ACCOs) not specifically funded for AOD activities also support clients with their AOD use.

Evidence

A 2022 systematic review of First Nations community-led AOD models of care starts by acknowledging that evidence is scarce, and much of what is available has been led by non-Indigenous researchers.[37]

The review identified seventeen (17) studies that evaluated community-based AOD programs for First Nations Australians. All programs were community-based and delivered either by outreach or at local community centres or community health services. All programs employed multi-modal/holistic therapeutic approaches, and addressed a range of AOD issues including alcohol, tobacco and other drug use. Several of the programs were single sex (for either men or women).

The review found evidence to support:

- Cultural safety – programs perceived by clients as culturally safe were more acceptable and effective.
- First Nations workers – Programs delivered by First Nations health and/or Social and Emotional Wellbeing (SEWB) workers were more acceptable to clients and were associated with improved client outcomes.
- First Nations community presence – Situating programs within an Aboriginal cultural context and settings was a key enabler to uptake and retention.
- Community outreach programs – These led to improved treatment access.
- Kin, family and cultural networks – Programs that focused on strengthening or re-establishing connection to family, kin and culture were highly valued by clients.
- On Country – holding a program On Country promoted healing while improving cultural safety and privacy.

Further, there is a growing body of evidence that demonstrates improved outcomes for Indigenous people accessing culturally responsive services (usually in community-led settings), both in Australia

[37] Krakouer et al (2022).

and elsewhere.[38] [39] [40] This is true not just for AOD, but other areas of health as well. Not only do First Nations models of care lead to improved outcomes for First Nations clients, but they avoid negative impacts that arise from medicalised Western models of AOD, including shame and stigma.[41]

While the empirical evidence is limited, what is available points to improved engagement and outcomes from community-led and/or culturally responsive and safe programs. This is supported by further advice, guidance and evidence given by First Nations service providers and clients that First Nations-led responses to AOD should be supported, promoted and prioritised.[42] [43]

However, Aboriginal community-led models are not a silver bullet. For example, some First Nations people may not know about community-led services or may wish to access mainstream services. The latter may be due to privacy concerns (i.e. the risk of knowing staff at a community-led service). Furthermore, like Victorian AOD services generally, demand for Aboriginal community-led AOD services far outstrips supply. Services providing culturally responsive services simply do not have capacity to meet demand.

5.2. Service provision recommendations

Recommendations:

5.2.1. The Victorian Government prioritise improving collection of First Nations AOD treatment data in both mainstream and community-controlled AOD providers as well as in the correctional system. Data should be made available in a manner consistent with the principles of Indigenous data sovereignty.

5.2.2. The Victorian Government increase funding for delivery of dedicated First Nations AOD services, including expanded service capacity in regional Victoria (particularly detox

[38] Harfield (2018) 'Characteristics of Indigenous primary care service delivery models: a systematic scoping review', *Globalization of Health*.
[39] Fomiatti et al (2023) 'Improving understandings of trauma and alcohol and other drug-related problems: A social research agenda', *International Journal of Drug Policy*.
[40] Munro et al (2017) 'The development of a healing model of care for an Indigenous drug and alcohol residential rehabilitation service: a community-based participatory research approach', *BioMed Central: Health & Justice.*
[41] Bryant et al (2022) 'The problem of over-medicalisation: How AOD disease models perpetuate inequity for young people with multiple disadvantage', *International Journal of Drug Policy*.
[42] Purcell-Khodr (2022) 'The importance of culture in alcohol care: Listening to First Nations staff in Australian Aboriginal Community Controlled Health Services', *The International Indigenous Policy Journal*.
[43] AHWPF (2023) *Victorian Aboriginal Health and Wellbeing Partnership Agreement Action Plan 2023-2025*, Aboriginal Health and Wellbeing Partnership Forum.

and residential rehabilitation services) and the urgent funding of additional Aboriginal women's treatment services.[44]

5.2.3. Increased investment for system navigation for First Nations Peoples, with an emphasis on Social and Emotional Wellbeing (SEWB) workers and cross-referrals between the mainstream and community-controlled sectors.

5.2.4. Invest in the development and implementation of First Nations models of care for AOD, focused on healing, community and culture.

5.3. Workforce

All Victorian Government-funded AOD services are required to provide a culturally safe environment for Aboriginal people. [45] As part of their funding, mainstream AOD services are expected to provide friendly, welcoming and culturally safe environments and provide service models that meet the needs of Aboriginal people. In pursuit of this, many organisations provide or procure training and education in First Nations cultural competency for their staff.

However, results from VAADA's 2023 *Workforce Development Survey* show that Victorian AOD workers have mixed levels of confidence in working with Aboriginal clients in a culturally safe manner.[46] More than 85% of Victorian AOD workers surveyed either Agreed or Strongly agreed that they 'have a strong understanding of the impact of historical and ongoing colonisation on Aboriginal and Torres Strait Islander communities.' Furthermore, fewer than 5% of respondents indicated that they did not have the capability to work effectively with First Nations clients. However, only 40.6% of workers agreed they have good working relationships with local ACCOs, and 48.8% indicating that they consult with Aboriginal workers to inform and strengthen their practice. Around 25% indicated that they did not have good working relationships with ACCOs and 20% that they did not consult with Aboriginal workers to inform their practice. These are missed opportunities as engagement with Aboriginal peoples and communities provides the possibilities to inform developments of relational, culturally responsive models of practice.[47]

[44] See VAADA's *State Budget Submission 2024* (accessed here).
[45] Department of Health, 'Alcohol and other drug program guidelines', Victorian Government (accessed here).
[46] VAADA (2023) *Victorian Alcohol and other Drugs Workforce Development Survey 2023*, Victorian Alcohol and Drug Association.
[47] Smith (2023) *The accounts of men in an Aboriginal-controlled Alcohol and other Drug Recovery Services: contributions to relationally-informed practice* [PhD thesis], Minerva Access (accessed here).

In addition, in circumstances where agencies employ Aboriginal AOD workers, there is a risk they are asked to carry a significant cultural load which also increases their risk of burn out.[48] 'Cultural load' refers to the often-invisible additional workload borne by Aboriginal and Torres Strait Islander people in the workplace. Cultural load is most likely to occur in workplaces where they are the only Indigenous person or one of only a few.

Notwithstanding the availability of resources such as the Australian Indigenous Health*InfoNet*, cultural load manifests in non-Indigenous workers expecting their Indigenous colleague(s) to educate them about First Nations people and culture and lead or consult on work with Indigenous clients. Further, Indigenous AOD workers experience additional cultural obligations when working with Indigenous clients, both in and outside of work hours. Services must also be aware of the risks of overloading Aboriginal workers and contributing to burn out.

Broadly, Victorian AOD workers report a strong understanding of the challenges faced by First Nations people, including of the need to ensure AOD services are safe and accessible for them. However, there is a need for ongoing education and training in First Nations cultural safety and consulting with local Aboriginal workers and/or services. Establishing a Victorian Aboriginal Alcohol and Drugs Council or similar body (see Recommendation 2) would also provide a central repository for First Nations AOD resources, education and workforce development opportunities in Victoria.

<u>Workforce recommendations</u>

5.3.1. The Victorian government commit to a review the Victorian AOD Skill Set (not updated since 2015) with a view to requiring mandatory completion of a module on First Nations Cultural Safety.

5.3.2. Expand support for First Nations Peoples to undertake AOD-related qualifications including those in healthcare and mental health, recognising and supporting pathways for those with lived-and-living experience of AOD use and the service system.

5.3.3. Support mainstream services funded to provide AOD supports to undertake regular cultural safety training and, where appropriate, resource them to develop culturally safe and accessible programs in partnership with Community Controlled organisations.

5.3.4. Support health sector leadership by mandating Aboriginal people are employed within the Department of Health at senior executive levels, with a plan developed for ongoing engagement and relationship building with Victorian Aboriginal communities.

[48] DCA (2023) *First Nations Identity Strain and Cultural Load at Work*, Diversity Council of Australia.

6. Conclusion

This section of the submission has provided a brief overview of challenges faced by First Nations Australians in accessing safe AOD-related healthcare in Victoria.

While it relied on non-Indigenous data and understandings of AOD, it offers important insights into histories of injustice faced by First Nations Peoples in the AOD service system, current challenges to equitable access and cultural safety, and recommendations for improvement. In its hearings related to the health system, Yoorrook should seek firsthand accounts from First Nations People who have experience of the AOD service system and AOD-related healthcare to best inform its recommendations for reform.

The next section reports on findings from a consultation with VAADA membership and the broader Victorian AOD sector. The final section provides accounts of six First Nations people working in the Victorian AOD service system.

Concluding recommendation

6.1.1. Yoorrook and any subsequent Aboriginal truth telling body collect first-hand accounts of First Nations People's experiences of Victoria's Alcohol and Other Drug service system to address historic and ongoing systemic injustices, with the goal of informing Aboriginal self-determination.

Recommendations summary

1. The Victorian Government commit to establishing a Victorian Aboriginal Alcohol and Drug Strategy in consultation with VACCHO, First Nations communities and services, and other relevant stakeholders including VAADA.
2. In conjunction with #1, the Victorian Government, in consultation with VACCHO, establish a First Nations AOD governance and leadership group to support development, delivery and implementation of the strategy as well as to represent Victorian Aboriginal Drug and Alcohol services and support First Nations leadership and self-determination in AOD.
3. The Victorian Government prioritise improving collection of First Nations AOD treatment data in both mainstream and community-controlled AOD providers as well as in the correctional system. Data should be made available in a manner consistent with the principles of Indigenous data sovereignty.
4. The Victorian Government increase funding for delivery of dedicated First Nations AOD services, including expanded service capacity in regional Victoria (particularly detox and residential

rehabilitation services) and the urgent funding of additional Aboriginal women's treatment services.

5. Increased investment for system navigation for First Nations Peoples, with an emphasis on Social and Emotional Wellbeing (SEWB) workers and cross-referrals between the mainstream and community-controlled sectors.
6. Invest in the development and implementation of First Nations models of care for AOD (including cultural supervision for First Nations workers), focused on healing, community and culture.
7. The Victorian Government commit to a review the Victorian AOD Skill Set (not updated since 2015) with a view to requiring mandatory completion of a module on First Nations Cultural Safety.
8. Expand support for First Nations Peoples to undertake AOD-related qualifications including those in healthcare and mental health, recognising and supporting pathways for those with lived-and-living experience of AOD use and the service system.
9. Support mainstream services funded to provide AOD supports to undertake regular cultural safety training and, where appropriate, resource them to develop culturally safe and accessible programs in partnership with Community Controlled organisations.
10. Support health sector leadership by mandating Aboriginal people are employed within the Department of Health at senior executive levels, with a plan developed for ongoing engagement and relationship building with Victorian Aboriginal communities.
11. Yoorrook and any subsequent Aboriginal truth telling body collect first-hand accounts of First Nations People's experiences of the Victorian Alcohol and Other Drug service system to address historic and ongoing systemic injustices, with the goal of informing Aboriginal self-determination.

Part Two: Sector Engagement

1. Introduction

This section of VAADA's submission to the Yoorrook Justice Commission's Inquiry into Health involved an online consultation with managers and executives from Alcohol and Other Drug (AOD) service providers in Victoria.[49]

Participating organisations were not Aboriginal community controlled (the Aboriginal Community Controlled sector was to be engaged directly via interview see: Part Three). While most participants were non-Indigenous, several First Nations people working in Cultural Advisor and Program Manager roles at these organisations attended.

The purpose of the sector consultation was to create an opportunity for discussion and critical reflection on the Victorian AOD system's history and current practice in relation to First Nations Peoples. It aims to provide important context for the first-hand accounts from First Nations People working in AOD in Part Three.

The broad query guiding the consultation was: "Does Victoria's AOD service system meet the needs of First Nations Peoples?" The group was separated randomly into two break-out rooms. The first group focused on First Nations clients and First Nations workers in the Victorian AOD system. The second focused on agencies and the AOD service system.

The breakout groups had 30 minutes for discussion followed by 20 minutes for feedback and shared reflection.

This paper discusses key themes that emerged from the consultation and includes de-identified quotes from participants (in italics).

2. Themes

<u>Acknowledging past wrongs</u>

Participants discussed the importance of acknowledging past wrongs perpetrated against First Nations Peoples within the health and social services systems, particularly by faith-based organisations (many of whom deliver AOD services). There was broad agreement that acknowledging past wrongs was crucial to improving service provision to First Nations clients as well as recruiting and supporting First Nations staff.

[49] Participants in the online forum self-selected in response to a request from VAADA to the Victorian AOD sector to be involved. 21 people attended the online forum, held on 31 January, 2024.

Several participants from faith-based organisations agreed, outlining their organisations' efforts to acknowledge and respond to historical injustices, including as part of their Reconciliation Action Plans. They also voiced personal and organisational commitments to improving access to and cultural safety within their services, including for First Nations staff.

> *I think they go hand in hand. Acknowledgement of historical wrongs and a commitment to do better are essential to an organisation seeking to increase work in this space [service delivery for First Nations clients].*

> *We've had Aboriginal clients, you know, for the entirety of our 45-year history. But we have responded to them individually. We had a desire to do better for Aboriginal people because, you know, we've let them down as a country in so many ways, that we should really prioritise them as a client group.*

Contemporary challenges

It was generally recognised that Victoria's mainstream AOD system has failed to meet the needs of First Nations people and continues to do so. While there have been important improvements in cultural safety for First Nations Peoples, particularly in recent years with the introduction of Reconciliation Action Plans and more widespread acceptance of the concepts of cultural safety and cultural responsiveness, significant challenges remain.

There was a consensus view that, while recent improvements are positive, there is still a long way to go. Challenges to further improvement include funding, 'invisible' bias in organisations policies and processes, and the burden on the Community Controlled sector to support mainstream sector reform.

> *We've always had the view that a good, strong service system should have both Aboriginal Community Controlled Organisations and Mainstream organisations that are culturally safe, so that Aboriginal clients have a choice.*

> *[F]ar too often we fall short and we're in fact not even able to appropriately connect with and engage and give First Nations people the confidence that they need to be able to engage in treatment in a mainstream [agency].*

> *But we didn't really know how and we didn't know where to start [developing their Reconciliation Action Plan]. And I think we just had to start reaching out to organisations and I think in those early days we found relationship building quite difficult. You know, many of the ACCHOs and Elders get absolutely smashed with*

being asked to be on so many different committees and things that take up a lot of time.

First Nations staff

Participants reflected on the burdens and challenges faced by First Nations staff working in AOD service provision, including cultural load and burnout. One participant reflected that organisational employment structures and processes can't account for the reality of what it is to be a First Nations staff member in a mainstream service, and the complexity of that role. For example, accounting for the labour of educating non-Indigenous staff on cultural safety, supporting non-Indigenous staff working with First Nations clients, and expectations from First Nations clients about support and availability outside of work hours.

Participants also discussed ways of supporting First Nations staff. These included formal structures like RAPs, inclusion policies and practices as well as smaller-scale actions like supporting staff to attend NAIDOC Week marches, celebrating key dates with cultural food and events, and flexibility around the January 26th public holiday.

Some larger organisations established First Nations staff groups, providing a safe space for staff to connect and support one another.

Aboriginal workers in mainstream services are poorly understood.

[First Nations workers carry the] cultural responsibility as a sage, for want of a better word, for the entire organisation.

You can't really just have one First Nations role because it's just not fair on the person. You need a team. Those roles can be really isolating, so it's about getting that critical mass.

Something we're trying here is our reconciliation lead has established Yarn Up! which is a group just for our First Nations workforce. So not just AOD either, across all of our services and they meet regularly to talk about, well, anything they want to talk about, really... And they have a direct link to the CEO's office to feed that information through. So, I think it's important that people have that accountability in an organisation where they can speak to leadership.

And to have the burden of being that person in the Aboriginal community, it's not, you know, we employ people 9:00 to 5:00, Monday to Friday, for example. They're [First Nations staff] on 24/7 in community. And so, the burden and the load for

Aboriginal people living in this space is enormous. And I don't think is adequately reflected in the way that we support people in the workplace to be, you know, not on deck.

Western models of health

Western clinical, health and service delivery models were widely recognised as a challenge for working with First Nations clients. On one hand, participants acknowledged the centrality of these models to their operation and the benefits such models provide.

However, participants also recognised that rigidity in the application of these models leads to poorer outcomes for First Nations clients, including early exits and incomplete treatment. Further, this can act as a barrier preventing First Nations people engaging with the service in the first place. A First Nations participant discussed the need to incorporate First Nations concepts of "healing" into care. They described this in terms of person-centred care, where the patient/client has a say in what their treatment looks like. In addition, Western Models of Health are inherently siloed with separate sectors responsible for separate areas of health care. This is antithetical to Aboriginal concepts of health and healing.

We're missing a cultural component of care.

The dominant psychological and psycho-social models are inadequate, plain and simple. CBT and medication are not culturally responsive and not necessarily the kind of treatment First Nations people want.

Embedding cultural healing in practice and ensuring that it's actually woven in and embedded, not just tacked on. 'Tacked on' is my phrase, but I'm picking up on the word embedded. We talked about some good examples and services that are Aboriginal-run yielding good outcomes that really have Aboriginal folk leading, driving and in charge of service delivery.

Access to culture, kin and country

Participants discussed the challenges of offering more culturally responsive care in the AOD sector. However, these challenges always offered opportunities to do better.

One participant described how a 'no phones' policy in their residential services disproportionately impacted First Nations clients, who were isolated from family and culture. Arranging phone calls with family and/or an Elder reduced isolation and increased people's resilience while in treatment.

Another participant described the 'tyranny of geography': the further a service, particularly a residential service, is from a person's family or country, the less likely they are to complete treatment.

> *And I, you know, I find where we [First Nations people] have access to culture, it helps to build the resilience and if we can try to find ways to make that more available to mob that are you know using AOD services, it just helps strengthen I think you know their resilience helps to strengthen their resolve in continuing recovery.*

> *There's not any other Aboriginal people in there [residential rehab] and a lack of, you know, being able to access other community [members] for, you know, for some cultural support while they're in those places that often feel very clinical.*

> *One thing that we've seen is that the further your service is away, especially for residential services, the less likely [First Nations] clients will stay because they are just so far from country, their connections, family visits and everything. Which is why we've advocated for our AOD system to have more smaller resis in the residential service space.*

Aboriginal loading

Participants agreed that the Aboriginal loading applied to funding (an additional 30% for work with First Nations clients) was critical to improving service provision to First Nations People. Not only does loading support a higher degree of care for vulnerable and/or complex clients, but also supported non-clinical aspects of work, such as trust and rapport building, cultural activities, and a more holistic approach to care (i.e. responding to adjacent, non-AOD needs).

However, participants acknowledged that larger organisations had much more capacity to undertake First Nations reforms, including hiring into cultural advisor roles, compared to smaller organisations. For smaller organisations, the additional loading for First Nations people supports one-on-one work with the client but not those broader structural reforms or organisations initiatives.

> *But for a lot of [First Nations clients] that I see, you know, I see them drinking and [using] drugs to cope with grief, loss and trauma, and there needs to be, I think, somewhere in there, some flexibility around the healing and you know, so people aren't looking to self-medicate so much.*

And it is really apparent to me that if we were going to make inroads in working with the Aboriginal community, we need to do it hand-in-hand with them and to build bridges with them about identifying what they want and need and what we can do to make a difference. And that's easy to say. But it's complicated.

Intersecting services; intersecting needs

While much of the discussion focused on opportunities for further improvement, some challenges remained intractable.

A key challenge was the criminal justice system, which was seen as undermining and working against the therapeutic goals of treatment, and the broader goals of AOD organisations. A tension was identified where prison was viewed as an inappropriate response, but where significant inroads should be made by improving access to AOD supports and treatments both in prisons and for people exiting prison.

One participant, coming from a hospital perspective, identified non-AOD harms as one of the primary barriers to achieving lasting outcomes with people. This respondent saw alcohol and drug use as quite manageable, but other issues, such as housing instability, domestic violence, and trauma as the intractable barriers.

And of course, there are a range of other systemic failures in our system that mitigate against, well, actually work against success in our sector. And this is why we put so much effort in the correctional system, because if we can get part of that right, we may have success [in other areas].

So, the majority of presentations I see are initially higher acuity AOD presentations with some acute health issues. Those things can be managed. But then we encounter the need for housing, for a stable environment, the need for support and for removal away from coercive control. These are the things that I don't see us as meeting.

Creating workforce opportunities and pathways

One key opportunity identified was the AOD sector as a potential employer for First Nations Peoples with experience of AOD. One participant – from a service organisation that is also a Registered Training Organisation – said many of their First Nations clients complete treatment go on to undertake training in AOD.

We've also found that supporting clients with RTO certificates and diplomas with sort of mentors or tutors to help them get through those courses. And that has built enormous goodwill.

Because I think for some [First Nations people in AOD treatment], if you don't have employment afterwards, they return to what they've already been through… If you don't have something to do with your time, if you're not contributing, it's such an easy thing to fall back into. It takes one little thing, a loss in the family or something, just to rock your boat. But yeah, if you're offered pathways for employment and education, you know those are, yeah, really positive, protective things. And if community know that, you know, you can do that, those options are out there, which I don't think a lot of community do, then that… just creates hope, creates pathways that are very optimistic.

Acknowledgement

VAADA would like to thank all those who participated in the sector consultation and acknowledge the important work they do in the Victorian community to support justice for First Nations Peoples.

List of participating organisations:

- Ballarat Community Health
- Barwon Health
- Bendigo Community Health Services
- EACH
- Gateway Health
- Gippsland Lakes Complete Health
- Odyssey House Victoria
- Salvation Army
- St Vincent's Hospital, Melbourne
- Thorne Harbour Health
- Uniting Vic/Tas
- Western Health
- Windana
- Your Community Health

Part Three: Interviews with First Nations People working in Victoria's AOD sector

This section is comprised of six (6) individual interviews conducted with First Nations People working in the Victorian AOD sector, conducted by Aboriginal consultant and Wurundjeri and Yorta Yorta man, Mark Thomson.

Interview were held with:

- Craig Holloway (Yorta Yorta) – Manager, Office of the Executive; Project Manager, Family Counselling Services and Special Projects and Innovations, Victorian Aboriginal Health Service.
- Paula Morgan (Gunnai) – CEO, Lakes Entrance Aboriginal Health Association
- Uncle Leslie Stanley (Yandruwandah Yarrawokka, Wulli Wulli) – Elder, Galiamble Men's Recovery Service (retired).
- Andrew Morrison (Gunditjmara) – Aboriginal Health Manager, Your Community Health.
- Nayuka Hood (Gunaikurnai) – Aboriginal Health Advisor, Uniting Vic/Tas.
- Daniel Wilson (Murri, Mbabaram) – Senior Aboriginal and Torres Strait Islander Cultural Advisor, Odyssey House Victoria.

A transcript of each interview has been provided to the Yoorrook Justice Commission as a separate file.