



“Not everyone has  
that support”



An evaluation of a series of harm reduction  
and AOD awareness activities within Victorian  
Aboriginal communities



The Victorian Aboriginal Community Controlled Health Organisation Inc.  
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Note on terminology: VACCHO acknowledges that although the terms ‘Aboriginal’ and ‘Indigenous’ have been used throughout this document, we are referring to both Aboriginal and Torres Strait Islander peoples in Victoria.

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## Executive Summary

Recent research indicates that Aboriginal people across Australia, including Victoria, are suffering high levels of both harmful psychoactive substance use and mental health-related morbidity.

In recognition of the trends in psychoactive substance use among Aboriginal people in Victoria, VACCHO convened a series of workshops and training sessions including pharmacotherapy professional development and accreditation sessions for General Practitioners (GPs), Aboriginal Mental Health First Aid (AMHFA) training to Aboriginal community participants, and Harm Reduction and Alcohol and Other Drug (AOD) Awareness workshops for Aboriginal community members and AOD service providers. These initiatives were funded as part of the AOD component of the Victorian Government's Koolin Balit Aboriginal health strategy.

Pharmacotherapy workshops were held in Bendigo, Bairnsdale and Melbourne with approximately 50 people attending, including 32 GPs and Registrars, and four Nurse Practitioners. All participants were accredited to prescribe pharmacotherapy treatments by completing the workshops successfully. Aboriginal Mental Health First Aid (AMHFA) community workshops (n = 10) were delivered across Victoria between May and August 2014, with eight new instructors trained to deliver the workshops. AMHFA training was less successful with minimal attendance and few evident prospects for uptake in the future.

Strong participation by Aboriginal participants in the Harm Reduction and AOD Awareness workshops across the state revealed their significant concerns about the availability, accessibility and appropriateness of AOD education and prevention, harm reduction and primary care, and rehabilitation services for their families and community members. Harm Reduction and AOD Awareness Workshops in each location attracted 30 or more participants each, who included the local Aboriginal community and AOD service providers at each of the eight sites. The workshops revealed:

- A widespread lack of knowledge and factual understanding about:
  - The effects and actual risks of psychoactive substances being used within the Aboriginal community beyond popular media representations;
  - The characteristics of addiction and dependency; and
  - The vulnerability of users to drug-related harms;
- Key and central problematic side-effects of lack of factual AOD information were:
  - Community stigmatisation of users;
  - Family shame; and
  - A tendency for public AOD discussion to focus solely upon policing, drug prohibition and community protection reinforced by Police Department leadership in some workshops;
- A disconnect between some AOD service providers and local Aboriginal people due to a lack of knowledge of both Aboriginal culture and Aboriginal service provision policy. Participants felt this was further exacerbated by,
  - Changes to funding for some Aboriginal-specific services (e.g. sobering up shelters, night patrols);
  - Lack of accessible and appropriate rehabilitation and detoxification services for 'ice' and poly drug use;
  - Psychiatric services lacking the capacity to respond to drug-related mental health problems;
  - Lack of systematic alcohol and drug awareness education in schools; and
  - AOD sector workforce and organisational capacity constraints.

Key strategies to address the challenges outlined above emergent from participants the workshops included:

- Increased Aboriginal cultural awareness of training of mainstream AOD providers;
- Increased specialist training for Aboriginal AOD workers through professional development and accredited courses;
- Increased age-appropriate AOD education in schools;
- Increased availability and accessibility of rehabilitation and detoxification services able to collaborate with Aboriginal families and incorporate Aboriginal cultural healing practices;
- Increased engagement with ex-users of alcohol and other drugs in education and harm and reduction strategies; and
- Engagement with families and Elders of AOD dependent users in advanced family care plans.

Key elements of the harm reduction approach that resonated with members of the Aboriginal community included:

- The need to nurture trusting relationships with users in order to be seen credibly as acting in their best interests. Data from the workshops indicated that a lack of useful information in the Aboriginal community has resulted in widespread stigma and shame being experienced by Aboriginal families with respect to psychoactive substance users within their families and a feeling of being unable to address it. Simple, family-based harm reduction interventions within the home can contribute to an increased sense of self-efficacy to Aboriginal families and enable maintenance of relationships with those affected in line with existing cultural and kinship obligations and responsibilities;
- Education of users, carers, advocates and families. As reported in the workshops, Aboriginal participants responded positively to harm reduction information when sufficient space was allocated to the subject within the workshops;
- Education of potential users. As indicated previously, Aboriginal participants felt more, earlier, and better AOD education in schools is required to equip young Aboriginal people with the skills and knowledge to make informed choices starting in primary school. Younger participants in the workshop indicated that current AOD education in schools is far from comprehensive; and
- Collaboration with carers and families to develop advanced care plans. Strengthening efforts to improve health and reduce harms associated with psychoactive substance use within Aboriginal families can be further strengthened by developing care plans for situations of crisis that may occur where family members are using psychoactive substances. Care plans could be adapted from similar plans such as the advanced care planning used in Victoria's mental health services. Simple harm reduction messages have proven effective when explained appropriately and space is available to communicate the concepts, especially when they are immediately credible to the family's or community's experience. Such a strategy would be implemented in parallel with the encouragement of relationship-building and simple family-based harm reduction strategies described earlier would be conveyed.

Key recommendations arising from the project that align with *Koolin Balit* outcomes and enablers include:

- Focus on harm reduction and demand reduction among young Aboriginal people;
  - Promote healthier lifestyles and harm reduction among young Aboriginal people who use psychoactive substances whilst building the evidence base;
  - Implement GetREADY (or similar evidence-based) AOD education lesson plans in schools;
  - Improve cultural responsiveness and accountability of mainstream service providers;

- Develop a pharmacotherapy strategy to improve Aboriginal identification and cultural responsiveness of trainers and pharmacotherapy networks;
  - Implement routine identification of Aboriginality among people receiving treatment for opioid-dependency;
  - Incorporate information and Aboriginal case studies into standard pharmacotherapy training courses;
  - Increase cultural safety awareness and accountability among current and new pharmacotherapy prescribers;
  - Develop Aboriginal patient engagement strategies in each Pharmacotherapy Area Network; and
- Cease offering AMHFA community workshops without prior request from ACCHOs or communities.

In addition, key recommendations that fell outside Koolin Balit’s scope, but in response to AOD issues more broadly, include:

- Improve cultural responsiveness of rehabilitation and detoxification services across the state;
  - Increase rehabilitation and detoxification places, especially in regional areas, to ensure Aboriginal people do not have to travel off country to access treatment;
  - Improve cultural responsiveness and remove barriers to access, with particular support for parents who require treatment for psychoactive substance use disorders; and
  - Increase focus of rehabilitation and detoxification services working with Aboriginal client families and carers.

Overall, a major requirement within the Aboriginal community is a strategy and series of initiatives that fundamentally shift the frame of perspective from one focused upon fear and anxiety and a punitive approach regarding psychoactive substance use to a primary health care frame including strategies focused on education, prevention, case management, harm reduction and long-term healing in a more holistic and comprehensive manner. To facilitate the requisite shift, governments and communities must arrest the reduction in funding and willingness to openly discuss and support effective, evidence-based initiatives based on harm reduction principles. As well as a renewed effort to utilise and promote the value of harm reduction programs and principles in efforts to improve Aboriginal health and wellbeing related to psychoactive substance use, additional focus on demand reduction will also ensure that much greater balance is achieved across all three pillars of Australia’s National Drug Strategy.

## Introduction

Recent research indicates that Aboriginal people across Australia, including the Victorian Aboriginal community, are suffering high levels of both harmful psychoactive substance use and mental health-related morbidity. Nationally, Aboriginal people are three times more likely to experience high and very high levels of psychological distress than non-Aboriginal people (1). Young Aboriginal people are also over-represented in mental health statistics, with psychoactive substance use and mental disorders explaining much of the health gap between Aboriginal and non-Aboriginal young people aged 15–34 years (2) such as the Victorian Government’s *Koolin Balit*, and the National Aboriginal and Torres Strait Islander Health Plan advocate improving health and mental health-related outcomes and equitable access to services (3).

Available evidence of psychoactive substance use among Aboriginal people in Victoria suggests Aboriginal people use psychoactive substances more often and in greater quantities than non-Aboriginal people. In a prevalence survey conducted by the Kirby Institute in partnership with VACCHO and others, young Aboriginal people (16 - 29 years old) were found to use drugs at higher rates compared to non-Aboriginal people. Both cannabis (21.3% vs. 30%) and methamphetamine (5% vs. 9%) use in the past 12 months was higher for young Aboriginal people (4,5). Similar rates of psychoactive substance use were identified in the National Aboriginal and Torres Strait Islander Health Survey. Compared to non-Aboriginal people, the NATSISS also found high levels of risky drinking in over 15 year olds, reported at 37% (6).

Aboriginal people in Victoria were also significantly overrepresented among Needle and Syringe Program (NSP) clients in 2012. Over 14% of Victorian NSP clients identified as an Aboriginal or Torres Strait Islander person (7), a similar rate found within national injecting drug user surveys (8). Aboriginal NSP clients in Victoria also had very high rates of Hepatitis C virus (HCV) with antibody prevalence 85% and 38% among Aboriginal men and women respectively compared to 69% for both non-Aboriginal men and women (7). National methadone and buprenorphine pharmacotherapy statistics also suggest Aboriginal people are well overrepresented, with 9% of clients identifying as Aboriginal in 2012 compared to Aboriginal people overall comprising just 2.5% of the population (9).

Overall, both national and Victorian data show the Victorian Aboriginal community experiencing high levels of mental health problems and psychoactive substance misuse. Despite the National Drug Strategy’s clear statement that “each of the pillars [of Australia’s National Drug Strategy 2010 – 2015] is equally important to the success of the strategy” most funding continues to be directed to just one pillar of the National Drug Strategy: supply reduction (law enforcement) (10,11). Demand reduction (prevention and treatment) remains low and harm reduction – one of the three pillars of Australia’s National Drug Strategy – receives just two per cent of direct government spending on illicit drug policy and actually decreased between 2002/03 and 2009/10 (11).

In recognition of the trends in psychoactive substance use among Aboriginal people in Victoria, the Victorian Government Department of Health and Human Services, under the AOD component of the Government’s *Koolin Balit* strategy, contracted VACCHO to convene a series of workshops and training sessions including pharmacotherapy professional development and accreditation sessions for General Practitioners (GPs) to administer methadone and buprenorphine pharmacotherapy treatments, Aboriginal Mental Health First Aid training to Aboriginal community participants and Harm Reduction and AOD Awareness workshops for Aboriginal community members and AOD and other service providers. While providing brief reports on the pharmacotherapy sessions and Aboriginal Mental Health First Aid training in the Methods and Discussion sections, primarily this report is focused on issues, challenges and solutions emergent from the latter series of Harm Reduction and AOD Awareness community workshops.

## About VACCHO

The Victorian Aboriginal Community Controlled Health Organisation (VACCHO) is the peak body for Aboriginal Health in Victoria advocating on behalf of and supporting a membership of 27 Aboriginal Community Controlled Health Organisations (ACCHOs). Each ACCHO in Victoria is unique in providing various services and creating particular partnership arrangements suited to local need.

At regular meetings of the 27 VACCHO member organisations, alcohol and other drug (AOD) use and the mental health of Aboriginal community members are voiced as priority areas. AOD and mental health programs within member organisations are provided in two main ways: (1) through programs that address social and cultural determinants, such as housing, justice, cultural knowledge development, early childhood and family support programs; and (2) by more clinical approaches available through general practice referrals, such as counselling, psychiatry and psychology services. The extent of any of these services for Aboriginal people varies at each ACCHO depending on funding, workforce availability, partnerships and community direction.

### Project Background

#### **Koolin Balit: Victorian Government strategic directions for Aboriginal health 2012–2022**

The Victorian Government's strategic directions for Aboriginal health are outlined in the *Koolin Balit* document. The Government's objectives are to:

- Close the gap in life expectancy for Aboriginal people living in Victoria;
- Reduce the differences in infant mortality rates, morbidity and low birthweights between the general population and Aboriginal people; and
- Improve access to services and outcomes for Aboriginal people.

The strategy's key priorities are:

1. A healthy start to life;
2. A healthy childhood;
3. A healthy transition to adulthood;
4. Caring for older people;
5. Addressing risk factors; and
6. Managing illness better with effective health services.



Koolin Balit outcomes relating to this project’s focus on psychoactive substance use are outlined below.

Figure 1: Relevant outcomes taken from the Victorian Government’s *Koolin Balit* strategy document.

Priority area	Relevant Outcomes	
	Direct	Indirect
A healthy start to life		- Decrease the percentage of Aboriginal babies with a low birthweight
A healthy childhood		
A healthy transition to adulthood	- Reduce the take-up of high-risk behaviours such as smoking, excessive alcohol consumption and use of illicit drugs	- Reduce the rate of Aboriginal young people with sexually transmitted diseases - Reduce the rate of presentations of young Aboriginal people to emergency departments for injury and self-harm - Improve access to mental health services earlier for young Aboriginal people
Caring for older people		
Addressing risk factors	- Reduce the proportion of Aboriginal Victorians drinking at risky and high-risk levels	- Reduce the rate of emergency department presentations due to alcohol consumption among Aboriginal people
Managing illness better with effective health services		- Improve Aboriginal people’s access to the range of health, mental health and other support services - Reduce preventable hospitalisation rates for chronic conditions for Aboriginal people - Reduce preventable hospital readmissions for Aboriginal people

**Note:** Adapted from *Koolin Balit: Victorian Government strategic directions for Aboriginal health 2012–2022*

The strategy's relevant enablers are presented below.

Figure 2: Relevant enablers taken from the Victorian Government's *Koolin Balit* strategy document.

Priority area	Relevant Enablers	
	Direct	Indirect
Improving data and evidence	<ul style="list-style-type: none"> <li>- Increase the range and quality of research and information to develop evidence-based interventions to improve the health of Aboriginal people in Victoria</li> </ul>	<ul style="list-style-type: none"> <li>- Improve health service planning and delivery for Aboriginal people through comprehensive and consistent information monitoring and management for data relating to Aboriginal health and service provision</li> </ul>
Strong Aboriginal Organisations	<ul style="list-style-type: none"> <li>- Provide opportunities for community leadership in program design and decision making</li> <li>- Support the strengthening of capacity and skills among ACCHO employees</li> </ul>	
Cultural responsiveness		<ul style="list-style-type: none"> <li>- Increase the cultural responsiveness of mainstream health and mental health providers so that Aboriginal people receive respect and high-quality care as a matter of course</li> <li>- Increase the capacity of mainstream health providers and their workforce to meet the health needs of Aboriginal people in Victoria</li> </ul>

Note: Adapted from *Koolin Balit: Victorian Government strategic directions for Aboriginal health 2012–2022*

### Project development

In late 2013 VACCHO was invited by the then Victorian Government Department of Health to submit a number of initiatives in line with *Koolin Balit* for the (at the time) current (2013/14) financial year.

In late March 2014 the Department funded VACCHO to deliver the following initiatives for the 2013/14 financial year:

1. Deliver three pharmacotherapy workshops in collaboration with Networking Health Victoria with a focus on Aboriginal patients;
2. Deliver 10 Aboriginal Mental Health First Aid community workshops;
3. Train six to eight new Aboriginal Mental Health First Aid instructors; and
4. Conduct eight to ten AOD and harm reduction awareness workshops.

## Methods

### Pharmacotherapy workshops – Methadone and buprenorphine training for GPs and Nurse Practitioners with a focus on Aboriginal patients

#### Aim

VACCHO partnered with Networking Health Victoria (NHV) to offer three pharmacotherapy workshops for General Practitioner and Nurse Practitioner participants to learn about diagnosing and treating opioid-dependency with a focus on Aboriginal patients. The workshops aimed to provide the skills and thus accreditation to prescribe pharmacotherapy for opioid dependence to both Aboriginal and non-Aboriginal people within the Victorian regulatory framework. Non-clinical workers including practice managers, AOD workers, Aboriginal Health Workers, and others were encouraged to attend in order to learn more about opioid dependency and treatment.

#### Instructors

Networking Health Victoria delivers the one day training sessions and maintains a list of very well qualified and experienced presenters. Dr Paul Grinzi co-facilitated two workshops, while Dr Gary Bourke, Dr Patrick Kinsella, and Dr Niall Quiry co-facilitated one workshop each.

#### Recruitment

VACCHO developed promotional flyers for the event and both VACCHO and NHV actively promoted the workshops through relevant networks including ACCHOs (GPs, CEOs, Practice Managers), GP networks, GP Registrars, VACCHO Members' meeting, VACCHO forums and events, other Aboriginal organisations, the justice system, pharmacotherapy area networks (PANs), Medicare Locals, RWAV, VACCHO social media contacts, and more.

#### Intervention sites

In consultation with VACCHO members and giving thought to the distribution of ACCHOs in Victoria, the workshops were held in Melbourne, Bendigo and Bairnsdale.

#### Participants

Turnout was consistent across each workshop, however Melbourne attracted a larger number of GPs.

Table 1: Pharmacotherapy training participants across all workshops.

Location and date	General Practitioner	Overseas trained doctor	Registrar	Nurse Practitioner	Other (not accredited prescribers)
Bendigo (28/6/14)	4	-	1	2	4
Bairnsdale (26/7/14)	8	-	1	1	7
Melbourne (27/7/14)	14	2	2	1	1
<b>Total</b>	<b>26</b>	<b>2</b>	<b>4</b>	<b>4</b>	<b>13</b>

**Note:** Statistics supplied by Networking Health Victoria.

Out of the totals above, five GPs worked in ACCHOs. Two other GPs that worked in ACCHOs had registered, however they were unable to attend for various reasons.

#### Participant evaluation

Data is collected and training delivery is evaluated by Networking Health Victoria who shared a summary with VACCHO. Rates of post-workshop prescribing among attendees will not be available for at least three months, however a review of the prescribing rates at 12 months is suggested.

## **Aboriginal Mental Health First Aid (AMHFA)**

VACCHO sought to increase capacity among the Aboriginal community in Victoria to give initial assistance to people with or developing a mental illness through the Aboriginal Mental Health First Aid (AMHFA) course. This was to be done by first, offering instructor training scholarships to six (later increased to eight) Aboriginal people interested in qualifying as an AMHFA instructor, and second, convening a series of workshops in the regions at which those instructors could upskill local Aboriginal community members as providers of mental health first aid interventions.

### **Instructors**

VACCHO employs two experienced AMHFA instructors who deliver training to ACCHO workers throughout Victoria and to other organisations on request.

The AMHFA scholarships (described below) funded Aboriginal applicants living in Victoria to complete the AMHFA instructor training course. Course graduation accredits people to deliver the 14-hour AMHFA course.

### **AMHFA Scholarships**

VACCHO was funded to offer six scholarships (later increased to eight – see below) for Aboriginal people living in Victoria to become AMHFA instructors through the Mental Health First Aid (MHFA) five-day training course to increase capacity for ongoing mental health training. Scholarships covered the instructor training course fee, tuition, catering, resources and membership but did not include travel, accommodation and other incidentals associated with course attendance.

Promotional flyers and expressions of interest (EOI) forms were developed and distributed across Victoria, with a focus on Aboriginal people working for VACCHO Members. The short project timeframe and upcoming AMHFA instructor training course meant that expressions of interest had short application deadlines. EOIs were sent out on 3 April 2014 with a deadline of 28 April 2014. VACCHO enquired with MHFA if additional AMHFA workshops would be held in 2014 or if a special training session could be organised, however no new courses were planned for 2014 and six to eight trainees was not a large enough group to offer a special, stand-alone session. VACCHO received 15 completed expressions of interest, with an additional five informal approaches. The training provider required all applicants to have a letter of support from their employer, which determined whether applicants met the course entry requirements following a full application using the MHFA course application forms. Full applications were submitted by 10 people.

Scholarships were awarded with preference given to Aboriginal people working in ACCHOs and other community controlled organisations. Eight people were successful in gaining a scholarship and all attended and graduated from the five day instructor training course. Scholarships covered all course instructor training fees, materials and catering, while the applicant was required to organise travel, accommodation and incidentals. The training was held at MHFA's head office in Carlton, Melbourne from 5 – 9 May 2014.

### **Community Workshops**

Each community workshop was the standard 14 hour AMHFA held over three days. The course covered four modules: Depression Disorders, Anxiety Disorders, Psychotic Disorders, and Alcohol and Drug Problems.

VACCHO recruited participants for the 10 AMHFA community workshops across Victoria between May and August 2014.

Workshops were held in the following locations:

- Swan Hill – 3-5 June;
- Frankston (southern metropolitan Melbourne) – 10-12 June;
- Echuca – 17-19 June;
- Mildura – 24-26 June;
- West Footscray (western metropolitan Melbourne) – 1-3 June;

- Horsham – 1-3 July;
- Box Hill (eastern metropolitan Melbourne) – 22-24 July;
- Bendigo – 29-31 July;
- Portland – 12-14 August; and
- Lake Tyers – 12-14 August.

### **Participants**

AMHFA training sessions are usually limited to less than 20 participants, ideally between 12 and 20 people. VACCHO received 165 registrations, an average of 16.5 people per workshop.

Converting registrations to workshop participants proved difficult. The aim of 150 participants was not reached despite high levels of interest. *'Sorry business'* - a funeral for a prominent community member - in Swan Hill meant that there was only one participant and many other sessions had people pull out in the days leading up to the training or they didn't present on the day. Strategies to maximise turnout were attempted including VACCHO staff members making numerous phone calls to replace late drop outs (resulting in a few extra participants) and several ACCHOs offering transport to the workshops.

Participants varied in age and were from a variety of employment backgrounds including sectors such as health, police and justice, administrative services, aged care, alcohol and other drugs as well as students and trainees.

Motivation for participant attendance included:

1. Relevance to current work
2. Give back to and assist Aboriginal community
3. General interest in mental health
4. Improve culturally appropriate response (non-Aboriginal participants)
5. Personal contact with mental illness (family member)

A summary of key questions from participant evaluations can be found in Appendix G.

## Harm Reduction and AOD Awareness Workshops

### Aim

The aim of the Harm Reduction and AOD Awareness workshops was to present locally relevant evidence-based information on alcohol and other drug-related harms along with strategies to address these. In addition VACCHO sought to identify local priorities and key themes and hotspots across Victoria.

### Instructors

VACCHO developed a facilitator brief (see Appendix E) and sought interest through its networks. Brad Pearce, Program Manager at the Victorian Alcohol and Drug Agency (VAADA), the peak body representing Alcohol and Other Drug (AOD) services in Victoria, was selected after submitting a formal proposal to deliver the workshops. Mr Pearce facilitated all workshops with the exception of Goolum Goolum (Horsham) which was facilitated by two members of the Wimmera Drug Action Taskforce.

A coordinator at each location was responsible for local promotion, venue hire, catering and confirming the workshop agenda with VACCHO. In addition to the facilitator, most workshops had at least one other presenter that covered topics deemed relevant by the local workshop coordinator. Presenters came from the local ACCHO, local service providers, and state-based organisations.

### Recruitment

Expressions of interest to hold an AOD and harm reduction awareness workshop were distributed to all VACCHO Members through email and at the VACCHO Members' meeting. Follow up phone calls were also made to seek interest from unresponsive members.

### Intervention sites

12 expressions of interest were received and eight workshops held. Workshops were held in the following VACCHO Member services (locations in parentheses where not obvious):

- Murray Valley Aboriginal Co-operative (Robinvale) – 17 July;
- Gunditjmara Aboriginal Co-operative (Warrnambool) – 22 July;
- Goolum Goolum Aboriginal Co-operative (Horsham) – 25 July;
- Ballarat & District Aboriginal Co-operative – 12 August;
- Gippsland & East Gippsland Aboriginal Co-operative (Bairnsdale) – 13 August;
- Gippsland & East Gippsland Aboriginal Co-operative (Morwell/Traralgon) – 21 August; and
- Wathaurong Aboriginal Co-operative (Geelong) – 29 August.

Mungabareena Aboriginal Co-operative and Albury Wodonga Aboriginal Health Service decided to withdraw their interest, Budja Budja withdrew interest at the time but remain interested in future workshops, and Ngwala Willumbong's expression of interest was withdrawn after the Victorian Government Department of Health advised that similar and more comprehensive activities were being undertaken by the eastern and southern metropolitan Melbourne regions (where Ngwala mainly operates) under existing regional *Koolin Balit* plans.

### Participants

VACCHO developed promotional flyers for most workshops, with separate flyers for the Aboriginal community and local service provider sessions. Workshops were promoted through a variety of mediums including email, phone calls, network meetings, flyers, Facebook, and mail.

Combined attendance at the workshops was approximately 300 – 350 people, with 150 participant evaluation forms completed and returned.

### Participant evaluation

A summary of participant evaluations can be found in Appendix H.

## Workshop Implementation

The workshop venues, content, facilitation style, modes of presentation and opportunities provided for participant input were, as indicated above, negotiated by VACCHO with the local coordinator and with input from the selected facilitator. As outlined further below, the content, styles of facilitation, presentations and opportunities for participant input at each workshop varied according to priorities and local political realities relevant to each local area.

The Harm Reduction and AOD Awareness workshop presentations were overwhelmingly didactic with periodic interruptions by participants asking questions or opining on a topic under discussion. The style of the project's main facilitator (Brad Pearce, VAADA) encouraged greater participation, however often other presenters were heavily didactic resulting in poor levels of participation. The didactic presentation method may have been favoured due to a lack of support, limited planning time, and project objectives being too broad and/or vague. Nevertheless, a considerable lack of adult learning principles and Aboriginal learning styles was evident across the board, a particularly disturbing finding regarding the capacity of local AOD agencies.

There was a conscious decision to allow ACCHOs to adapt the workshop to more accurately reflect local priorities and to encourage ACCHOs to take a lead role resulted in some incongruence across the sessions. This resulted in eight very different workshops which did not combine well to achieve the project's original harm reduction awareness objectives. The vastly different audiences (i.e. local service providers and local community members) reflected a fundamental conflict in workshop aims which remained unresolved due a lack of planning time given funding for all the activities within this project were received just three months prior to the end of the financial year. Workshops with one presenter and logically sequenced topics (i.e. harm reduction-related) encouraged greater audience participation, providing a strong, consistent narrative. However, the short implementation time-frame resulted in VACCHO's coordinating role becoming overstretched and a lack of time to provide greater guidance in workshop planning with most workshops consisting of several incongruent presenters and topics that significantly deviated from the central harm reduction narrative.

Workshop structure was also influenced by the strength of Aboriginal community participation. Workshops with a poor turnout were unable to follow the original agenda requiring the facilitator to adapt the session to meet the needs of participants present. This was done in consultation with the ACCHO and VACCHO.

Each workshop's structure was biased towards the morning session resulting in turnout being consistently stronger at these. Afternoon sessions often finished early due to a diminishing number of participants or a poor turnout. Two workshops maintained strong participation in the morning and afternoon (Goolum Goolum and Wathaurong) being the only two workshops with extensive pre-workshop planning.

Strongly didactic presentations with little room for participants to ask questions and provide comment perhaps unsurprisingly led to poor participant engagement. Results from the workshop evaluation forms show little difference in participant ratings of the workshop quality which were consistently positive, however when prompted for feedback participants of more didactic sessions suggested more general discussion time, shorter presentations, more community voices, and more interactivity would have been preferable.

Most workshops were not held at the ACCHO and many were held some distance away, although most were centrally located in the city/town. The location did not seem to greatly influence the number of Aboriginal community members or local service providers attending. Transport for community members was only arranged for two workshops with greatly different numbers of community members attending (one had a large and the other a small turnout). It would appear that the only effect on turnout may have been choosing a venue on location of the local high school and negotiating with the school to allow Aboriginal school students to attend. However, in this instance, the higher turnout could be related to a greater level of planning and commitment at a community level.

All workshops were held during the working week, and this may have also had an impact on limiting the number of community members who were interested in attending but could not.

## Results and Findings

### Response of the Aboriginal community to alcohol and other drug/harm reduction workshops

Overall, each of the workshops attracted about 30 or more participants, who included the local Aboriginal community and AOD service providers at each of the eight sites. On average, a third of the participants were from the local Aboriginal community with the rest being non-Aboriginal people employed by local service providers.

The responses of Aboriginal participants revealed a lack of detailed knowledge about the provenance and effects of psychoactive substances being used within their community including emergent specific questions about “ice” and synthetic cannabis. A lack of knowledge was evident about addiction, dependency and the vulnerability of users to drug-related harms. The broad lack of knowledge depth and information to some extent reflected a communication disconnect between the Aboriginal community and AOD service providers and educators (see below).

Nevertheless, a more problematic side-effect of this lack of information was the tendency of some Aboriginal participants in the workshops to default towards discussions of policing, drug prohibition and community protection, such as, challenging the promotion of needle and syringe programs for harm reduction purposes suggesting these encouraged drug use. Stigmatisation of users and shame associated with family drug use emerged as common within the Aboriginal community, as portrayed by carers and former substance users,

*“(My) kids ended up in DHS, I lost my job, lost my family’s respect...I told my 14 year old girl, she was in tears. How could you do that?”*

\* \* \*

Q: *“Michelle . . . the bit that struck me was about Elders (not understanding young people)?*

A: *“Aunties, uncles, did not support me and I had to deal with it on my own . . . I had to find support in friends . . . [and local health service] workers . . . [I was] treated like a black sheep . . . disconnected . . . [it was] very hard to get support from [aunties and uncles].*

Q: *“What do you do to keep strong?”*

A: *“Talk with other Indigenous people, do a lot of art projects, keep connected to community, go for walks . . . connect with nature . . . [re family support?] . . . no connection there . . . just my immediate family . . . [my] sons.”*

\* \* \*

*“Eventually someone told me to call psych services in Ballarat . . . and that was the best thing . . . that was the most embarrassing time of my life . . . I can’t explain . . . how much that one phone call, it meant so much . . . Even though I was putting on a big front, but . . . yeah, that’s what we do isn’t it? . . . this is not usually something I’d share . . . my 24 year old son went back to an eight or 10 year old (in hospital) . . . he was not a pretty sight to see . . . (crying out to me when I arrived), ‘Mummy, mummy, get me out of here!’ . . . and playing with toys.”*

A punitive perspective towards alcohol and other drug use was reinforced by some police department participants in the workshops proposing somewhat simplistic approaches to the complexities of alcohol and other drug use, such as, advocating approaches including “say no to drugs,” provide “tough love,” administer “domestic house rules” regarding psychoactive substance use, along with conditional entreaties to partner the Aboriginal community, such as, “we need respect.”

Some GPs and social workers persisted in framing discussions of working with the Aboriginal community in deficit terms: despair, sadness and loss rather than acknowledging existing Aboriginal community assets.

Extant Aboriginal poverty and low socio-economic status was highlighted by numerous participants identifying key social determinants of health associated with problematic alcohol and other drug use, such as:



- Lack of affordable housing availability - particularly former substance-dependent people attempting to re-establish their lives;
- Lack of local employment opportunities; and
- Lack of public transport.

Beyond the specific alcohol and other drug program context examined in the next section, other broader challenges identified by both Aboriginal and other participants included observations that:

- Substance users were regularly going to court, while drug dealers were left “running free”;
- That it appeared easier for an Aboriginal person to get into police custody than into a drug rehabilitation facility;
- That substance-dependent Aboriginal people are often incarcerated without medical support to detox or manage their dependency; and
- Concern from carers and families about safety during (Ice-related) psychotic episodes.

While the Aboriginal community participants who attended the workshop appeared to have had minimal exposure to harm reduction approaches to alcohol and other drug use, when provided with further information they demonstrated a strong interest and queried the apparent absence of leadership regarding harm reduction locally, in the media and within popular policy discourse.

### **What were the barriers to alcohol and other drugs and harm reduction services identified in common by Aboriginal people and service providers?**

A resource constrained alcohol and other drug program context was identified by Aboriginal and non-Aboriginal participants at all sites as a barrier to effective service provision. These resource constraints included:

- The loss of what the Aboriginal community perceived as established successful Aboriginal-specific programs: sobering up shelters, night patrols and youth counselling services;
- The limited accessibility and appropriateness of AOD detoxification and rehabilitation facilities and subsequent discharge follow-up services;
- A lack of AOD education in schools;
- Workforce capacity constraints due to inadequate staff qualifications and lack of ongoing training and professional development; and
- A disconnect between AOD services and the Aboriginal community.

### **Perceived loss of some harm reduction services to the Aboriginal community**

At several workshops Aboriginal participants cited the loss of services such as sobering up centres<sup>1</sup> and/or a night bus that provided intoxicated individuals with either a safe place or transport home. Previously, these services were viewed as effective harm reduction measures for the Aboriginal community,

*“... ‘cause a lot of our people that were non-violent . . . [were able to sober up] for their own safety”.*

Loss of safety measures (both physical and cultural) has led to police taking a greater role. Police shared their procedures regarding intoxicated individuals at several workshops,

*“We have a custodial nurse...they are in regular contact with [the person in custody] . . . they’re treated in custody.”*

<sup>1</sup> The Victorian Department of Health and Human Services advised that “Gippsland & East Gippsland Aboriginal Cooperative in Bairnsdale, Rumbalara Aboriginal Cooperative (in Shepparton-Mooroopna) and Mallee District Aboriginal Cooperative (in Mildura) undertook local Aboriginal community consultations to change their service model in 2010 and 2011. This resulted in removing the sobering up functions and focusing specifically on AOD support and intervention”.

*“[They’re] triaged [for mental health]”*

In some instances, these procedures were disputed by Aboriginal participants.

Detoxification of people in custody was cited by one police officer as an activity they were quite good at as,

*“Often they would leave the next day in better shape.”*

It was widely agreed that using police custody for detoxification was far from ideal, and at one workshop a police officer admitted reluctance of being placed in the position of keeping people safe (as in a sobering up centre) because the person needed specialised medical care, especially in the case of illicit drugs where the quantity and quality of the substance (or more commonly *substances*) used was unknown.

Participants believed that budget cuts had resulted in the loss of youth counselling services and this was identified as problematic by Aboriginal participants.

### **Lack of accessible and appropriate rehabilitation and detoxification services**

A lack of nearby alcohol and other drug rehabilitation and detoxification services and poor responses to needs were the most consistently raised challenges by Aboriginal participants and local services around the state. Participants in some workshops cited restricted hours of access to rehabilitation and detoxification services (Monday – Friday, 9.00am - 5.00pm) as inadequate to the needs of people seeking support.

According to participants, client places were insufficient to meet demand creating considerable waiting times. Participants reported that rehabilitation and detoxification are mostly set up for heroin addiction and characterised by a lack of both expertise and pharmacotherapy measures for Ice and poly drug use. For most local communities, drug rehabilitation and detoxification services were located at some distance such that it was impossible for carers and families, and thus relevant local cultural protocols, to be included in these programs. Participants identified the default position of relying on the justice system and associated unnecessary and inappropriate incarceration and death as some of the real consequences. One Aboriginal service provider reported,

*“I’ve lost six clients in the last 12 months . . . aged in the late 30s and 40s, and one 26 year old.”*

Poor transition from AOD rehabilitation and detoxification services and prison into everyday life was a serious concern for Aboriginal community participants,

*“They’re not ready to come back.”*

*“He just went back to the same [drug using] house.”*

*“Two-three weeks later they’re back in the same place.”*

One Aboriginal participant, formerly dependent on Ice reported,

*“The scariest part of rehab is when I leave that gate.”*

Better support during the transition from rehabilitation (and prison) to everyday life was critical to many participants. High rates of relapse and death among Aboriginal people are widely held, rational fears:

- Six deaths in 12 months of Aboriginal people who had transitioned from rehabilitation were recalled by one worker, in one community; and
- *“they’re not ready to come back...2-3 weeks later they’re back in the same place”.*

Two ACCHOs in Albury and Wodonga who expressed an interest in holding Harm Reduction and AOD Awareness workshops made a decision not to proceed until their pressing need for a rehabilitation service received a response. Workers at these ACCHOs reported spending a disproportionate amount of time trying to organise rehabilitation places and travelling with clients to Melbourne.

### Case study: DIY Detox - An Aboriginal family's response to being turned away

While waiting times for accessing alcohol and other drug detoxification and rehabilitation services around Victoria continue to increase, one Aboriginal family took matters into their own hands.

After years of using all kinds of drugs, Robyn\* was ready to start the process of detoxification and rehabilitation. However when she was told to wait at least two weeks for a place in detox, Robyn and her family decided they had to act now. Robyn's family refitted their house and rearranged their lives to give her the help she couldn't get anywhere else. Her mother Nicole\* set up a family roster to maintain a 24 hour watch and support Robyn through her

detox. Looking after Robyn's son during her detox was just another job that the family took in their stride.

After 11 days, when Robyn was through the worst, the family received a call from the detox service saying a place had become available. Nicole doesn't like thinking about what would have happened if the family wasn't there to support her daughter. But they pulled together and Robyn is now focused on keeping herself and her son healthy and safe. Robyn was lucky her family was there when she was turned away from detox. Nicole feels for other people turned away from services when they seek help. Not everyone has a family as strong as theirs that won't take no for an answer.

\* Names changed for confidentiality

### Psychiatric services not responding well to drug-related mental health problems

Aboriginal participants in the workshops primarily viewed psychiatric services as providers of respite care for families caring for family members with chronic mental health disorders and also identified their limited capacity to provide services subsequent to discharge<sup>2</sup>.

According to two Aboriginal participants caring for family members,

*"Once [he is] in psychosis mode he goes down to Ballarat . . . that's when you get relief"*

*"He got the help he wanted, he went through the situation . . . admitted for 28 days, then released . . . so he came back home . . . was on psych drugs . . . but didn't want to take 'em. Now he's dabbling again . . . the [AOD and psychiatric] service(s) says he's doing good, but we know he's dabbling again."*

A large number of participants at one workshop were frustrated at their inability to involuntarily admit people with both ice-related psychosis and mental health problems who were causing problems when the community was unable to support that person.

A senior worker at a psychiatric service responded by identifying their inability to respond well to drug-related mental health problems.

*"The difficulty is that the mental health and psych services aren't set up for people with drug addiction . . . they're designed for people with a mental illness . . . detox and rehab is not a role . . . there's a bit of a gap there."*

Distance to psychiatric services also caused problems for participants, with several people in regional areas advocating for psychiatric services in or closer to their town,

*"Will we ever get a (psychiatric) service in Horsham like there is in Ballarat?"*

### Lack of alcohol and other drug education in schools

Many participants felt the lack of substantive AOD education in schools was leading to higher rates of use and abuse. The general sentiment was that AOD education needed to begin in primary school (age-

2 The Victorian Department of Health and Human Services advised that "there is often a gap between what communities expect and want from psychiatric services and what services are able to provide. This highlights the importance of building relationships at the local level to address issues and develop locally relevant and effective service responses".

appropriate). Participants across several workshops described young Aboriginal people becoming inured to AOD use in the family home, for instance, both mum and dad smoking “*yarni*” (marijuana) at home leading to acceptance and “normalising” AOD use from an early age. Family breakdown and family violence were also described as common challenges that exacerbated AOD use. Normalisation of AOD use in family homes was reported as common across several communities involved in the workshops.

The broad lack of engagement of young people was a concern among Aboriginal people at most workshops. Young people, according to the organisers, were “not part of” the ACCHO at one workshop, were observed as being quite bored at another and were reported as “not getting” the AOD education they needed in several communities. Goolum Goolum was the only workshop to attract a large number of young people and perhaps not coincidentally was the only site to plan for young people’s attendance by holding it on the grounds of the high school. Nevertheless, no specific opportunity was made available at the workshop for Aboriginal young people to discuss their problems and potential solutions. At the Goolum Goolum workshop potential input was through an anonymous SMS question line.

Participants at most workshops suggested they knew the problems and solutions for young people. Many observed that local services were inadequate to their needs and it is likely that many needs of young Aboriginal people are either unmet or misunderstood through their lack of facilitated engagement. Without young peoples’ attendance and engagement, their unique situation cannot be fully understood.

### **Workforce and organisational capacity constraints**

Aboriginal community respondents and service providers identified specific gaps in AOD workforce capacity within service agencies in their areas. With regard to local Aboriginal workers in the sector they noted that Aboriginal alcohol and other drug workers appeared to be employed in positions that were fairly generalist in scope requiring no specialist qualifications in the AOD field. Furthermore, they observed that these workers seemed to be offered little further training or ongoing professional development to progress their career in the sector. Some observers attributed these issues to the relatively low pay scales for Aboriginal AOD workers relative to Aboriginal workers in other areas of the health workforce.

With regard to non-Aboriginal AOD workers in the sector, Aboriginal participants observed many were limited in their ability to engage the Aboriginal community either due to organisational structures and processes, or a lack of the necessary cross-cultural professional skills.

### **AOD and other local services disconnected**

Many Aboriginal people felt community services were not responding or listening to their needs, while many non-Aboriginal participants seemed to lack an understanding of how to engage with Aboriginal people and communities generally.

Some local service providers felt it was difficult for mainstream services to engage with Aboriginal people, for example, suggestions that responsibility lay with those people not engaging rather than the organisation and the worker ensuring accessible and appropriate services,

*“How do we get people to engage – that’s the major hurdle...it’s themselves.”*

The ‘Aboriginal people aren’t engaging with us’ standpoint was evident at several workshops, with many service workers feeling it was not their responsibility to actively and persistently engage, instead taking a more passive approach or making a small number of unsuccessful attempts. Whether this was due to structural and systemic barriers (e.g. inflexible workplaces and those not encouraging persistent engagement and relationship building attempts) or other reasons was not explored.

During group work sessions within the workshops, there were several occasions where the views and priorities of mainstream non-Aboriginal workers were significantly different from Aboriginal people and workers. Such differences often remained unacknowledged by the mainstream service workers. The prevalence of these ways of working in the workshops signalled some significant service delivery implications, not least the ability of AOD workers to engage with and respond to the priorities of the Aboriginal community rather than their own preconceived priorities.

Several Aboriginal participants detailed inadequate responses by local service providers highlighting a general lack of empathy with Aboriginal people and the crises they face in a context of marginalisation

and poverty, and an understanding of how to engage appropriately and really understand their needs. Inadequate responses appeared to cause many Aboriginal participants to be reluctant to contact or engage with AOD services thus actually driving further marginalisation. Examples reported in workshops included:

- Police disrespecting the contextual knowledge of an ACCHO manager in their after-hours response towards Ice users;
- Telephone counsellors being inexperienced (“little voice coming back”) and disrespectful (“suck it up, he’s your son”); and
- AOD services refusing to assist carers and family members of AOD-dependent people.

At some workshops police asked participants to contact them about Ice and other AOD problems, however several people expressed frustration at poor previous responses leading to poor outcomes. The history of police-Aboriginal relations appeared absent in a police participant’s suggestion that breaking down communication barriers relied on Aboriginal people making the effort to introduce themselves to new police officers in town,

*“The best way to break down barriers is for you to say ‘hello’ walking down the street.”*

Such a suggestion implies policing as confined to the informal relationship between an officer and an individual rather than as a set of organisational public service practices guided by corporate policy and procedures that would, at least in an ideal world, acknowledge the prior history of police-Aboriginal relations and thus take a more proactive stance to the provision of accessible and appropriate service provision.

In the AOD system a lack of engagement and understanding of Aboriginal peoples’ needs was identified as a major and significant barrier to service access. Aboriginal parents with AOD problems reported being reluctant to access rehabilitation services not only due to long waiting times, but the family-unfriendly requirement to travel long distances (usually off-country) and their fear of losing their children to child protection.

### **What initiatives did Aboriginal people and service providers propose in common to address alcohol and other drugs and harm reduction locally?**

Proposed initiatives varied greatly, however most came back to the necessity of trust and credibility. The omnipresent trust and credibility gap has been exacerbated by a large number of recent Ice-related forums and a lack of action based on the community’s suggestions, perpetuating views of inaction and marginalisation.

#### **Education of mainstream providers**

Feelings of trust and credibility towards mainstream service providers were wanting. Responses from Aboriginal participants revealed a desire for mainstream service providers to take responsibility for poor engagement and begin proactively engaging with and genuinely understanding the needs and priorities of Aboriginal organisations and communities,

*“when it gets down to it, what do staff actually know?”*

*“it’s not all on paper”*

*“...it’s really important to get to know community outside (the) clinical (relationship)...come to Wathaurong, NAIDOC, flag raising...”*

*“Lots of people don’t understand...they don’t live through the crisis we are going through...”*

Aboriginal participants asked mainstream services to ask and listen to what Aboriginal people and communities need, making them central players in decision making and service allocation prioritisation (“they want to solve our problems...but they don’t ask us”). In an example from a training institution, this meant developing traineeships and scholarships based on people’s desired study rather than pushing out specific courses that local Aboriginal people weren’t interested in.

## **AOD education in schools**

The current model practiced by participants was entirely focused on client deficits, with no capacity to focus on “preventative funding over band-aid funding”. Aboriginal participants and local service providers emphasised the critical importance of building strengths and resilience among young Aboriginal people from an early age in school:

*“(there are) a lot of services 0-5, 12-18, but nothing in between”*

The necessity of school-based AOD education was identified in most group work and raised in most plenary sessions as a key way of addressing systematic AOD problems.

## **Training for Aboriginal AOD workers**

The AOD workforce and other workers in ACCHOs are often the first resource families seek advice, especially given the credibility gap mainstream services have acquired state-wide.

*“I want to know everything and I want to know now...”*

*“[It would be great] if it was my family and I know I can go to one of these nurses (who know about AOD and psych-related things)...is there someone I can go to at Goolum Goolum?”*

*“[My 16 year old daughter]...her son, he was five years old...she was really dependent...she hit rock bottom...there was no support for me...I saw Kit-e (ACCHO worker)[to ask her what I could do]...there’s not a lot out there for parents...If I walked into a drug and alcohol service and said my daughter has a problem they’d tell me to get out [and get her to come in]...I’d have to step back (from her daughter, not enable her) so she could acknowledge she had a problem...”*

When significant problems arise in the community, AOD and ACCHO workers are best placed to build expertise in order to ensure community members have a resource that is credible and trustworthy.

There is a surfeit of alcohol, Ice and other drug information often misconstrued as understanding:

*“...everyone knows about (drug) education now, we’re experts...”*

A void of expertise in service delivery responses and harm reduction was revealed despite a string of Ice forums, a Parliamentary Inquiry, and extensive media coverage. Workers did not have answers to important questions for community members, including a deficit of simple harm reduction strategies to ameliorate harms.

Aboriginal participants suggested AOD or ACCHO workers be trained as local Ice experts for the community. This would provide a model for future community AOD concerns and create critical local capacity to respond to AOD problems with a harm reduction focus. Training in the delivery of community-based harm reduction strategies would build on the trust and credibility of ACCHOs and offer some answers to families seeking support at their first point of call.

## **Increase availability and accessibility of rehabilitation and detoxification services**

Trust and credibility in the system that responds to problematic substance use is hamstrung by both real and perceived deficits in rehabilitation and detoxification services. A lack of local, responsive AOD rehabilitation services contributed to a high level of frustration and in the case of two ACCHOs was given as the reason to cease planning for a harm reduction workshop (Albury/Wodonga). There are however pragmatic undercurrents that could be tapped:

*“I wanna know when are we going to get rehab in Latrobe? When are we getting help? It doesn’t matter if it’s cultural or what, just, black or white, we need rehab...even if it’s just one that does Moe, Morwell, Traralgon...”*

*“...there’s no rehab beds, they always say you’ll have to wait.....so what we ended up doing, me and a worker from Mildura...is [detoxing a man] at (the worker’s) house...but then he (the substance user) just went back to the same house”*

## **Work with families**

Rehabilitation and detoxification services need to be responsive (timely) so people don't lose motivation and build on the strength of the person's connection to their family whenever possible and practical (also see the earlier case study):

*"...if I didn't have my five kids, I wouldn't be here..."*

Travelling long distances off-country and risking the involvement of child protection services are obstacles that dissuade many Aboriginal potential clients from seeking help. Given the government's history of forced child removal continues with extremely high rates of child protection orders among Aboriginal people in Victoria, these fears are real and traumatic. Rehabilitation services must be educated, culturally safe, flexible, and accommodative of the family responsibilities incumbent upon many young Aboriginal parents with children.

*"...her big fear was 'when I go to detox will they take my son, will they give me a red flag...?'"*

Whilst acknowledging that not everyone has support of their family, for those people the barriers loom larger,

*"...not everyone has that support..."*

*"Aunties, uncles, did not support me and I had to deal with it on my own..."*

These stories also highlight the pressure that community members place on substance users, expecting them to 'be fixed' after one attempt. This stigma is discussed in more detail elsewhere in the report.

## **Users of alcohol and other drugs to be involved and distribute harm reduction messages**

*"If you inject it, you're a junkie"*

*"[We] use glass pipes"*

*"[I] can still buy 'em (glass pipe) [at] any Chinese or tobacco shop [despite being banned in Victoria]"*

*"[M]ost people smoke (Ice) who I know"*

*"[It costs] \$100 a point [here]"*

Such were the insights of former Ice users. Not one participant at any workshop other than former substance users came close to offering such a credible account of what psychoactive substance use looks like in Aboriginal communities. Credibility is paramount when developing messages to resonate with people using psychoactive substances, and most other areas of life, for example, generational difference, which as one Elder put it,

*"young people tell us Elders 'you don't know what it's like'"*

Unfortunately, genuine concern for problematic substance users was overwhelmed by poor understanding of addiction and substance seeking behaviours,

*"try (Ice) once and that's it"*

*"you gotta think about your organs"*

While the disconnect between local service providers and Aboriginal communities is ever-present, so too was the disconnect between Aboriginal participants' understanding of AOD and actual substance user behaviour. Perhaps more concerning was the refusal among many local service providers, including those working at ACCHOs, to develop a more nuanced approach to working with psychoactive substance users. As identified earlier in the report, knowledge of harm reduction is not widespread and the context people usually develop resources, projects and programs is one that sees psychoactive substance use as a social evil, which is evidence-based and creates barriers to engagement.

In order to overcome systemic, institutionalised moralistic barriers, trust must be built with substance users in a context outside current service delivery mechanisms that are unable to reach them. Trust is the necessary precursor to constructing credible messages that begin to reach (allegedly) large numbers of disengaged substance users.

## **Involve Aboriginal families, including resource development such as care plans**

The critical involvement of families in the healing process has been highlighted in examples within this report. There are every day examples of family and community members helping to keep substance users healthy and safe too,

*“My thing is offering them a shower and a coffee...”*

Family often extends beyond the nuclear, and in that sense, a more fluid and broader understanding of family by mainstream service providers is necessary in AOD-related areas. When rich, personal understanding is ignored or not valued it leads to sub-standard care,

*“...the [AOD and psychiatric] service(s) says he’s doing good, but we (referring to immediate family and community) know he’s dabbling again...”*

*“[the] Police laughed in my face when I told them to lock her up,...then I got angry...another time I pretty much told the Police not to lock a girl up [but they did]...”*

Increasing and improving support for Aboriginal parents, grandparents and families with an AOD-dependent family member was also a commonly raised priority. One ACCHO decided to independently investigate the feasibility of a family support group for Aboriginal people, however several community members present voiced scepticism at the usefulness of this, desiring something more tangible and practical. When developing resources it was important to listen to the audience’s concerns and realities. One suggestion to develop care plans received stronger support,

*“[The ACCHO] could keep confidential files on the person, family...they keep a file there and with consultation with family...and the family says we don’t want to drop her off at A, B, C, D...and [we] tell the Police (audience agreement – “yeah, that’s good”)...you want them to get better...”*

## **Include Elders**

Increased involvement of community Elders was also an important part of building trust and credibility in some communities,

*“Elders sharing their stories...when it comes from government [it doesn’t have the same impact]...they can share their stories...the things they’ve been through”*

*“I’ve been suicidal...and I talked to me Elders”*

Participants also recognised the limits of the involvement of Elders, which should be appropriate and reflect practicalities and limitations of knowledge. Importantly AOD harm reduction should not be distorted to placate abstinence-only views at the expense of evidence-based strategies, especially when even Elders acknowledge there are limitations to their understanding,

*“young people tell us Elders, ‘you don’t know what it’s like’”*



## Discussion

As identified in the introduction, whilst commenting on the pharmacotherapy and Aboriginal Mental Health First Aid initiatives, primarily this report focuses on issues, challenges and solutions emergent from the Harm Reduction and AOD Awareness workshops in order to guide future activities and policy related to *Koolin Balit* and other AOD-related initiatives for Aboriginal people in Victoria.

### Pharmacotherapy workshops – Methadone and buprenorphine training for GPs and Nurse Practitioners with a focus on Aboriginal patients

**Stronger focus on responding to the needs of Aboriginal patients should be maintained and improved**

Impetus to deliver the pharmacotherapy workshops originated from VACCHO Member feedback and VACCHO's evidence review which highlighted the significant overrepresentation of Aboriginal people with an opioid dependency problem. Immediate perceptions of the workshop via a post-workshop evaluation in Bairnsdale suggested a subjectively effective workshop, with 55% of people indicating they intend to prescribe. Further results are tabled below.

Table 2: Selected results from Bairnsdale post-workshop evaluation.

	Not met at all	Partially met	Completely met
Recognise, prevent and respond to problematic pharmaceutical opioid use	11%	-	89%
Have increased knowledge on how to safely and effectively prescribe buprenorphine and/or methadone for opioid dependence	-	8%	92%

Victoria does not routinely collect Aboriginal status when issuing new permits for methadone or buprenorphine, however informal discussions with Networking Health Victoria (the training provider) and GPs throughout the workshops reinforced VACCHO's view that Aboriginal people are overrepresented among this patient group in Victoria. It is our view that adding a compulsory question on the permit asking the person if they identify as an Aboriginal and/or Torres Strait Islander person and training these service providers in skilful ways to ask this question would vastly improve service planning and response for Aboriginal patients.

Despite regular emails, phone calls and networking, variable interest from GPs working in ACCHOs translated into few additional prescribers (five) in ACCHOs at the project's end. Encouragingly, invitations to ACCHO workers not able to prescribe (e.g. practice managers, AOD workers, Aboriginal Health Workers, etc.) were higher than expected and their feedback on the training was very positive. These participants also commented on the usefulness of meeting and networking with GPs and similar workers in regional areas (Bendigo and Bairnsdale) – it being the first time they had attended such a meeting. On the other hand however, informally, GPs and trainers felt the presence of non-prescribers negatively impacted on course delivery. Data does not exist to provide comment to influence future decisions on the ideal participant mix.

**Data does not exist to provide comment to influence future decisions on the ideal participant mix.**

After a low GP turnout at the Bendigo workshop, Networking Health Victoria in collaboration with the Pharmacotherapy Area Network (PAN) representative in Gippsland organised three face-to-face introductory module (pre-requisite to the full day module two component delivered in the workshop, also available online) training sessions during weekday evenings which appeared to generate more interest and enrolments in the full day training course. It may be worthwhile trialling introductory module sessions with invitations extended to non-GP ACCHO workers in order to increase awareness of the over-representation of opioid-dependence among Aboriginal people.

**It may be worthwhile trialling face-to-face introductory module pharmacotherapy training sessions with invitations extended to non-GP ACCHO workers**

Networking Health Victoria enlisted one of their GP trainers to update the standard course material to give the training a greater focus on Aboriginal patients. The GP made minor adjustments to a role play

scenario in collaboration with an Aboriginal Health Worker. VACCHO provided trainers with relevant background information on opioid dependence among Aboriginal people, statistics on related health and mental health problems, and barriers to seeking help. Changes to materials were minor and it would be easy to permanently incorporate information relating to Aboriginal patients into NHV's standard pharmacotherapy course, with emphasis on the need for GPs (and nurse practitioners) to ensure they understand or seek help to understand what a culturally safe model of care looks like for Aboriginal people given the high rates of opioid dependency.

## **Aboriginal Mental Health First Aid**

### **A highly rated initiative which has exhausted interest among community members at this point in time**

Evidence of very high rates of mental health problems among Aboriginal people and a well-received community AMHFA workshop trial in 2012 by VACCHO and the Victorian Aboriginal Health Service (VAHS) provided the basis for these workshops.

Despite lessons from the 2012 trial being adopted (e.g. later starts and earlier finishes to accommodate parents and carers) and significant investment in promotion and recruitment by VACCHO and Members, turnout was low at most workshops. Pre-workshop registrations were on target, however free transport, home visits, phone calls and more could not help convert registrations to turnout. Several hypotheses for the high registration, low turnout scenario were put forward by instructors, for example, the lack of financial investment required of participants (workshops were free), however we are unable to test the validity of any.

Participants generally worked in health and mental health-related fields including justice-related professions, however Elders, reception and administrative workers and people with home duties also attended.

Participants rated the workshops and the instructors extremely positively. However, the poor turnout in light of little associated costs and heavy promotion by VACCHO and our Members suggests that genuine interest from community members is not high enough at this time to continue offering AMHFA community workshops. The strongest interest for the course remains among Aboriginal and non-Aboriginal people employed in positions that directly and indirectly interact with Aboriginal people with mental health-related problems.

Should interest arise from local community members or from local organisations, the project has increased VACCHO's and local communities' capacity and availability of Aboriginal people trained to be AMHFA instructors.

## **Harm reduction and AOD Awareness workshops**

### **Broad concern about AOD within the Aboriginal community**

Strong participation by Aboriginal participants in the Harm Reduction and AOD Awareness workshops across the state revealed their significant concerns about the availability, accessibility and appropriateness of AOD education and prevention, harm reduction, primary care, and rehabilitation services for their families and community members. Of particular concern was their lack of access to current, evidence-based information regarding particular psychoactive substances in use across the broader community, simple harm reduction strategies useful to them in their engagement with family members using these substances, and unfettered access to support services from AOD agencies in their localities and regions. Importantly for planning purposes service providers and governments, views on psychoactive substance priorities varied in each community. Aboriginal participants demonstrated strong support for harm reduction once presented with clear, evidence-based information regarding psychoactive substances, their use, potential effects and what they themselves could do to engage with users in a useful way. However, in the absence of credible and effective education programs providing clear, evidence-based information, fear, shame, isolation, and dependence on outside authorities imbued Aboriginal participant responses.

Overcoming initial negative responses to known effective harm reduction practices will require a sustained focus on building trust and credibility with agencies and community members. For instance, responses to harm reduction strategies such as utilising former drug users as educators in schools, were seemingly thought by some workshop participants to be a strategy to scare young people into not taking drugs and seen as a lesser measure compared with dissuading "even just one person" from using drugs. Further highlighting these obstacles to AOD prevention and harm reduction strategies created by a lack

of community AOD education was in opposition to existing successful, evidence-based prevention and harm reduction models already supported by the government (e.g. GetREADY). Informal discussions outside plenary sessions uncovered this model's existing operation within the Aboriginal community in at least one location (Shepparton) that may inform other Aboriginal communities in Victoria. Such models allow young people autonomy and place trust in their ability to understand and interpret the concepts involved when in real world situations.

A key concern within these localities and regions was the dominant discourse regarding the harmful use of alcohol and other drugs that framed it almost exclusively as anti-social, dangerous and/or illegal behaviour potentially harmful to others. This framing promoted widespread fear and anxiety and prompted a punitive mindset calling for responses such as social isolation through either incarceration or segregation rather than framing psychoactive substance use as a widespread health issue requiring education, prevention, case management, harm reduction and long-term healing in a more holistic and comprehensive manner. Where authorities such as the police led or dominated the conversation in these workshops, this dominant discourse was pervasive within the sessions. It was evident that some police perceived incarceration as a therapeutic public service despite the long-standing findings from the Royal Commission into Aboriginal Deaths in Custody (RCIADIC 1991). Such perspectives reflect an organisational culture with a very limited understanding of Aboriginal peoples, culture and history and the capacity and commitment of Aboriginal families to care for their own, as well as their role in the health and safety of people using psychoactive substances.

A similar lack of awareness and understanding of Aboriginal peoples was also displayed by many other non-Aboriginal local service providers through their behaviour toward Aboriginal participants in small group discussions. Many service providers viewed themselves as experts in the administration and provision of services to Aboriginal people by virtue of their role. Such service providers gave negligible recognition to the substantial experience and local knowledge of Aboriginal participants with psychoactive substance issues in their lives and their perceptions of the barriers, challenges, potential solutions and priorities. The standpoint of these service providers reinforced a perception of a disconnect between AOD service providers, the Aboriginal community and Aboriginal clients.

### **Resource constrained AOD program context**

The evident disconnect between some AOD service providers and the Aboriginal community also seemed to arise as a result of the resource constrained context of AOD service provision in local and regional communities. Many of these communities expressed feelings of loss of AOD support services viewed as important and immediately practical that kept individuals and families safer (for example, sobering up shelters and night patrols) and also several also lamented the loss or significant service reductions of agencies such as Primary Care Connect. Changes to services such as these have led to frustration and fundamental ruptures in trust, which had been built with these services over long periods of time. Budgetary constraints may have restricted further specialist professional development of the AOD workforce particularly regarding building their competence to work with the Aboriginal community more effectively<sup>3</sup>. Likewise, budgetary constraints within the education system may have contributed to the lack of relevant and appropriate AOD education within schools.

Many observations and recollections by Aboriginal participants demonstrated no connection with the concept of *cultural responsiveness* made explicit in *Koolin Balit: Victorian Government strategic directions for Aboriginal health 2012–2022*, which declares that,

*Cultural responsiveness* refers to healthcare services being respectful of, and relevant to, the health beliefs, health practices and cultural needs of Aboriginal communities (Department of Health 2009). Cultural responsiveness is more than cultural awareness. Awareness is only a first step. What matters is how organisations and individuals within each organisation behave as a result of that awareness.

Organisations need to put processes and systems in place if they are to achieve cultural change and to embed it in everyday behaviour. Cultural awareness and sensitivity are building blocks; cultural responsiveness is the desired outcome... if Aboriginal people are to get the

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<sup>3</sup> This is partly being addressed through a series of cultural safety workshops run by VACCHO (funded by the Victorian Department of Health and Human Services) throughout the AOD sector in 2015, however requires an ongoing and persistent commitment beyond these.

healthcare they need, mainstream providers must understand their healthcare needs and the most effective way to deliver services to them. This, in turn, means that health providers must understand and be responsive to local Aboriginal people and culture, including social, spiritual, emotional and physical wellbeing, as well as gender related health needs. Without this, Aboriginal people are less likely to access services that are critical to good health, and if they do access them, are less likely to come back, understand their treatment needs or comply with treatment regimes. (p60)

Therefore, it is incumbent on organisations and service providers in the AOD and peripheral arenas to create a culturally responsive workforce to work hand-in-hand with the Aboriginal community.

It is exactly this way of working, based upon a trusting relationship that is the foundation for effective psychoactive substance harm reduction approaches within the Aboriginal community.

Nevertheless, the current situation is that the Aboriginal community is experiencing a lack of trustworthy and credible support for psychoactive substance users and for carers, advocates and family members. Observations of several interactions between Aboriginal and non-Aboriginal participants and prevailing attitudes of some non-Aboriginal participants further demonstrated this disconnection and systemic lack of cultural responsiveness.

Despite commitments such as *Koolin Balit* and organisational level strategies, it appears that the Aboriginal community is being viewed by some agencies as one of numerous “minority” groups absent any specific uniqueness to distinguish local Aboriginal culture, or more concerning, as one cultural group of many in ‘multicultural’ Australia who, in the face of the dominant culture, ought to “get with the [mainstream] program”. There is significant area for improvement among many organisations and despite previously highlighted resource constraints, these organisations must overhaul the way they do business to fulfill explicit obligations relating to culture and respect for Aboriginal peoples’ needs identified in *Koolin Balit* and other strategies. The status of *Koolin Balit*-related obligations revealed during this project suggests that mainstream organisations’ engagement and response to the needs of the Aboriginal community needs to be held to a higher level of scrutiny and accountability which includes redesigning systems so that the needs, voices and feedback from Aboriginal communities is actively sought and acted upon; that is, establishing a two-way process respected by the Aboriginal community and the service provider.

### **Key elements of an effective harm reduction approach with the Aboriginal community**

AOD workshops providing a broad-based forum for local AOD service providers – for instance local Police – ) to present their particular perspective on the issues are ineffective mechanisms to deliver clear harm reduction and health-related messages related to psychoactive substance use in the Aboriginal community. Across these agencies, a poor understanding of harm reduction and psychoactive substances topics is evident resulting in an overall emphasis framed within a fearful and punitive paradigm. The obvious disconnect between service providers and the Aboriginal community they purport to support also inhibited the development of a two-way learning process. A high level of ignorance first, amongst some AOD and other service workers regarding both local Aboriginal people and their service delivery responsibilities towards them, and second, the widespread lack of AOD education within Aboriginal families and communities tainted most discussions prohibiting any real progress towards the development of practical, evidence-based harm reduction objectives. While proposed as a simple and potentially effective mechanism to raise awareness regarding psychoactive substances and harm reduction approaches, the design of these workshops proved to be an ineffective approach to reduce AOD associated harms impacting Aboriginal people and progressing real outcomes under *Koolin Balit* or otherwise.

Nevertheless, in some instances, the workshops allowed glimpses of what an effective harm reduction intervention looks like. Where clear information and explanations were provided within the workshops regarding the nature of psychoactive substances, addiction, dependence and psychoactive substance-related harms along with practical harm reductions measures to take when a family member was involved, Aboriginal participants demonstrated tremendous interest and an obvious willingness to look after their kin.

Key elements of the harm reduction approach that resonated with members of the Aboriginal community included:

- The need to nurture trusting relationships with users in order to be seen credibly as acting in their

best interests. Data from the workshops indicated that a lack of useful information in the Aboriginal community has resulted in widespread stigma and shame being experienced by Aboriginal families with respect to psychoactive substance users within their families and a feeling of being unable to address it. Simple, family-based harm reduction interventions within the home can contribute to an increased sense of self-efficacy to Aboriginal families and enable them to maintain relationships with those affected in line with existing cultural and kinship obligations and responsibilities;

- Education of users, carers, advocates and families. As reported in the workshops, Aboriginal participants responded positively to harm reduction information when sufficient space was allocated to the subject within the workshops;
- Education of potential users. As indicated previously, Aboriginal participants felt more, earlier, and better AOD education in schools is required to equip young Aboriginal people with the skills and knowledge to make informed choices starting in primary school. Younger participants in the workshop indicated that current AOD education in schools is far from comprehensive; and
- Collaboration with carers and families to develop advanced care plans. Strengthening efforts to improve health and reduce harms associated with psychoactive substance use within Aboriginal families can be further strengthened by developing care plans for situations of crisis that may occur where family members are using psychoactive substances. Care plans could be adapted from similar plans such as the advanced care planning used in Victoria's mental health services. Simple harm reduction messages have proven effective when explained appropriately and space is available to communicate the concepts, especially when they are immediately credible to the family's or community's experience. Such a strategy would be implemented in parallel with the encouragement of relationship-building and simple family-based harm reduction strategies described earlier would be conveyed.

**A strategy and series of initiatives is needed that fundamentally shift the perspective of psychoactive substance use from one based on fear, anxiety and punishment**

Overall, a major requirement within the Aboriginal community is a strategy and series of initiatives that fundamentally shift the frame of perspective from one focused upon fear and anxiety and a punitive approach regarding psychoactive substance use to a primary health care frame including strategies focused on education, prevention, case management, harm reduction and long-term healing in a more holistic and comprehensive manner.

## Conclusion

All initiatives reinforced perceptions and data that suggest Aboriginal people experience higher levels of psychoactive substance-related harms, however prioritisation of psychoactive substances differs in each community. Significant interest in use and misuse of alcohol and other drugs relating to Aboriginal people from community members and local services persists, however views were often drawn from reactive, emotionally charged examples which biased debate towards worry, fear, and anxiety.

Unfortunately, trust and credibility problems plague perceptions and relationships between the Aboriginal community and Aboriginal people who use psychoactive substances. Psychoactive substance literacy in the community appears to be low despite substance-related information reaching saturation levels through previous forums, interventions, and campaigns, and is almost wholly based on negative examples. The discourse stubbornly remains framed by a deficit view with law enforcement and justice system prioritised over the health of a person and also that of a community.

One of the principal findings of this project was the systemic lack of trust and credibility which the AOD sector and its peripheral systems have with the Aboriginal community. This seems to relate to service provider agency disruption from recent sector reforms, and a continued disconnect between service providers and the Aboriginal community driven by a persistent inability or reluctance of service providers to seek out and respond to the real priorities of the local Aboriginal community.

Resilience in adversity is demonstrated by many Aboriginal communities and families, responding to poor access to services and a lack of service provider engagement with creative solutions by families and communities. This ranges from detoxification services in the family home (complete with a roster system) to simple harm reduction strategies such as offering a shower and coffee to someone experiencing Ice-induced paranoia. Failure of service providers to listen and learn from such acts of generosity is an injustice to the tireless work of many Aboriginal community members. However, these responses are not performed by or in consultation with qualified, experienced workers. Further, due to widespread misunderstanding and stigma towards psychoactive substance use and addiction, especially illicit substances, health promotion and harm reduction messages are inaccessible to many Aboriginal people using psychoactive substances. They are instead problematised and stigmatised.

Problems, barriers, and opportunities related to psychoactive substance use among Aboriginal people in Victoria transcend *Koolin Balit* priorities and initiatives. Extant child protection, housing, alcohol and other drug sector, employment and education institutions and their structures, policies and programs act as barriers to improving psychoactive substance-related health and mental health. From a Aboriginal perspective, it requires a comprehensive inter-sectorial holistic approach - an Aboriginal. For this reason this report presented qualitative data as raised by local Aboriginal people themselves without confining or aligning data categories to pre-defined *Koolin Balit* specific program areas. Therefore, to meet requirements of the Department of Health, recommendations are formatted into those that relate specifically to *Koolin Balit* and those that do not directly align.

Overall, this project trialled some new and innovative ways to progress psychoactive substance and mental health-related health. The pharmacotherapy workshops increased access to methadone and buprenorphine treatments in ACCHOs and other services as well as introducing ACCHO workers other than GPs to new ideas and networks, whilst the AMHFA community workshops helped address prevailing stigmas and knowledge. However, interest appears to have largely been exhausted among these groups at this point in time. Fundamentally, there is a pressing need to focus on removing barriers that systematically marginalise psychoactive substance users in the Aboriginal community and deter service access.

Promisingly, clear, credible information and explanations regarding the nature of psychoactive substances, addiction, dependence and psychoactive substance-related harms resonated with the Aboriginal community's real and lived experience just as comprehensively as existing negative perceptions when delivered by a credible and trustworthy source.

Marrying trustworthy and credible sources – as viewed by the Aboriginal community and/or Aboriginal psychoactive substance users – with evidence-based measures, especially relating to harm reduction, should be the new standard in the Aboriginal AOD arena. Critically, trust and credibility cannot be rushed, and there should be a renewed emphasis on planned, patient development of strategies and initiatives within a *health* discourse. New, innovative and strategic health and harm reduction-focused

initiatives are required to challenge prevailing punitive and marginalising viewpoints. Each must be tailored in ways that target specific audiences, each with an equally trustworthy and credible messenger if improvements in substance-related health indicators are to be realised.

## Recommendations

### Recommendations that contribute directly to Koolin Balit outcomes and enablers

Recommendation	Agency/ies	Koolin Balit Outcomes	Koolin Balit Enablers	Time-frame
<b>Harm Reduction and AOD Awareness Workshops</b>				
<p>Promote healthier lifestyles and harm reduction among young Aboriginal people who use psychoactive substances whilst building the evidence base</p> <p><i>Priority area: A healthy transition to adulthood</i></p> <p><i>Enabler areas: (1) Improving data and evidence; (2) Strong Aboriginal organisations</i></p> <p>Vision:</p> <p>To address systemic barriers (identified in this report) in psychoactive substance use by facilitating a shift in the paradigm of psychoactive substance use among people who use psychoactive substances and health professionals from fear, anxiety, social segregation and punitive approaches to one founded upon health and empowerment of people who use psychoactive substances and their carers and families.</p> <p>Aims:</p> <ol style="list-style-type: none"> <li>1) Build the evidence base</li> <li>2) Promote healthier lifestyles and reduce risks associated with psychoactive substance use among young Aboriginal people in two communities</li> </ol>	VACCHO and partners	<ul style="list-style-type: none"> <li>- Reduce the take-up of high-risk behaviours such as smoking, excessive alcohol consumption and use of illicit drugs</li> <li>- Reduce the proportion of Aboriginal Victorians drinking at risky and high-risk levels</li> <li>- Reduce the rate of Aboriginal young people with sexually transmitted diseases</li> <li>- Reduce the rate of presentations of young Aboriginal people to emergency departments for injury and self-harm</li> </ul>	<ul style="list-style-type: none"> <li>- Increase the range and quality of research and information to develop evidence-based interventions to improve the health of Aboriginal people in Victoria</li> <li>- Provide opportunities for community leadership in program design and decision making</li> <li>- Support the strengthening of capacity and skills among ACCHO employees</li> </ul>	2014 – 2017



Recommendation	Agency/ies	Koolin Balit Outcomes	Koolin Balit Enablers	Time-frame
<b>Harm Reduction and AOD Awareness Workshops</b>				
<p>Implement GetREADY (or similar evidence-based) AOD education lesson plans in schools</p> <p><i>Priority area: A healthy transition to adulthood</i></p> <p>Expand evidence-based school AOD education to all schools, beginning with schools with Koori Education Support Officers</p>	<p>DEECD, DHHS, VACCHO, VAEAI and partners</p>	<ul style="list-style-type: none"> <li>- Reduce the take-up of high-risk behaviours such as smoking, excessive alcohol consumption and use of illicit drugs</li> <li>- Reduce the proportion of Aboriginal Victorians drinking at risky and high-risk levels</li> </ul>		<p>2015 – 2018</p>
<p>Improve accountability and cultural safety of mainstream service providers</p> <p><i>Priority area: Managing illness better with effective health services</i></p> <p><i>Enabler area: Cultural responsiveness</i></p> <p>Mainstream service providers to develop better ways to listen and respond to needs of Aboriginal people using alcohol and other drugs, and families of people using alcohol and other drugs, in line with the understanding of cultural responsiveness in <i>Koolin Balit</i></p>	<p>Mainstream service providers, DHHS, VAADA, and partners</p>	<ul style="list-style-type: none"> <li>- Reduce the take-up of high-risk behaviours such as smoking, excessive alcohol consumption and use of illicit drugs</li> <li>- Reduce the proportion of Aboriginal Victorians drinking at risky and high-risk levels</li> </ul>		<p>2014 – 2015</p>
<p>Develop practical, psychoactive substance-related crisis resources with Aboriginal families and carers</p> <p><i>Enabler area: Strong Aboriginal organisations</i></p> <p>Develop practical family resources and family-based harm reduction strategies and explore how care plans can be used to respond to situation of psychoactive substance use-related crisis</p>	<p>VACCHO and partners</p>		<ul style="list-style-type: none"> <li>- Provide opportunities for community leadership in program design and decision making</li> </ul>	<p>2015 – 2018</p>

Recommendation	Agency/ies	Koolin Balit Outcomes	Koolin Balit Enablers	Time-frame
<b>Harm Reduction and AOD Awareness Workshops</b>				
<p>Trial a needle vending machine in an ACCHO</p> <p><i>Priority area: Managing illness better with effective health services</i></p> <p>Trial a needle vending machine in at least one ACCHO</p>	VACCHO and partner/s	- Improve Aboriginal people's access to the range of health, mental health and other support services		2015 – 2016
<p>Identify research priorities with ACCHOs and community members</p> <p><i>Enabler area: Strong Aboriginal organisations</i></p> <p>Identify psychoactive substance-related research priorities with VACCHO members and community members as central planners and decision makers and ensure researchers and researchers act in a culturally responsive manner in line with <i>Koolin Balit</i></p>	VACCHO and its Members, Researchers, Research Institutes		- Provide opportunities for community leadership in program design and decision making	2014 – 2015
<b>Pharmacotherapy workshops – Methadone and buprenorphine training for GPs and Nurse Practitioners with a focus on Aboriginal patients</b>				
<p>Implement routine identification of Aboriginality among people receiving treatment for opioid-dependency</p> <p><i>Priority area: Managing illness better with effective health services</i></p> <p><i>Enabler area: Improving data and evidence</i></p> <p>Update the prescriber permit form to ask if the person is Aboriginal and/or Torres Strait Islander to build an evidence-base for better service planning, delivery and response</p>	DHHS	- Improve the coordination and integration of services for Aboriginal people accessing and moving between health care settings	- Improve health service planning and delivery for Aboriginal people through comprehensive and consistent information monitoring and management for data relating to Aboriginal health and service provision	2015

Recommendation	Agency/ies	Koolin Balit Outcomes	Koolin Balit Enablers	Time-frame
<b>Harm Reduction and AOD Awareness Workshops</b>				
<p>Incorporate information and Aboriginal case studies into standard pharmacotherapy training courses</p> <p><i>Enabler area: Cultural responsiveness</i></p> <p>Incorporate case studies, statistics, barriers and enablers relating to opioid-dependence among Aboriginal people into standard pharmacotherapy training slides.</p>	<p>NHV, VACCHO</p>		<ul style="list-style-type: none"> <li>- Increase the cultural responsiveness of mainstream health and mental health providers so that Aboriginal people receive respect and high-quality care as a matter of course</li> <li>- Increase the capacity of mainstream health providers and their workforce to meet the health needs of Aboriginal people in Victoria</li> </ul>	<p>2015 – 2016</p>
<p>Increase cultural safety awareness and accountability among current and new pharmacotherapy prescribers</p> <p><i>Enabler area: Cultural responsiveness</i></p> <p>Increase awareness and accountability of Aboriginal cultural safety among key pharmacotherapy stakeholders such as Networking Health Victoria, Pharmacotherapy Area Networks, and current and new pharmacotherapy prescribers through Reconciliation Action Plans (or similar). Ensure NHV’s core pharmacotherapy trainers have a strong understanding of Aboriginal cultural safety and understand cultural responsiveness.</p>	<p>DHHS, NHV, Pharmacotherapy Area Networks, GPs</p>	<ul style="list-style-type: none"> <li>- Improve Aboriginal people’s access to the range of health, mental health and other support services</li> </ul>	<ul style="list-style-type: none"> <li>- Increase the cultural responsiveness of mainstream health and mental health providers so that Aboriginal people receive respect and high-quality care as a matter of course</li> <li>- Increase the capacity of mainstream health providers and their workforce to meet the health needs of Aboriginal people in Victoria</li> </ul>	<p>2015 –</p>

Recommendation	Agency/ies	Koolin Balit Outcomes	Koolin Balit Enablers	Time-frame
<b>Harm Reduction and AOD Awareness Workshops</b>				
<p>Develop Aboriginal patient engagement strategies in each Pharmacotherapy Area Network</p> <p><i>Enabler area: Cultural responsiveness</i></p> <p>Each Pharmacotherapy Area Network to develop a strategy to engage GPs in ACCHOs (for example, trial face to face module one sessions and encourage GPs in ACCHOs as well as critical support staff such as CEOs, practice managers, medical receptionists and AOD workers to establish a pharmacotherapy service in more ACCHOs)</p>	<p>NHV, Pharmacotherapy Area Networks, VACCHO, ACCHOs, DHHS</p>		<ul style="list-style-type: none"> <li>- Increase the cultural responsiveness of mainstream health and mental health providers so that Aboriginal people receive respect and high-quality care as a matter of course</li> <li>- Increase the capacity of mainstream health providers and their workforce to meet the health needs of Aboriginal people in Victoria</li> </ul>	<p>2015 –</p>
<b>Aboriginal Mental Health First Aid (AMHFA)</b>				
<p>Cease offering AMHFA community workshops without prior request</p> <p><i>Enabler area: Strong Aboriginal organisations</i></p> <p>Only deliver AMHFA community workshops when ACCHOs and/or communities request them rather than delivering workshops without specific requests</p>	<p>DHHS, VACCHO</p>		<ul style="list-style-type: none"> <li>- Provide opportunities for community leadership in program design and decision making</li> <li>- Support ACCHOs in positioning themselves for the future and in meeting the health needs of Aboriginal people in Victoria through quality governance and management</li> </ul>	<p>2015 –</p>

**Recommendations that address Aboriginal community needs in relation to psychoactive substance use that fall outside Koolin Balit**

Recommendation	Agency/ies	Expected benefits	Timeframe
<b>Harm Reduction and AOD Awareness Workshops</b>			
<p>Increase rehabilitation and detoxification places, especially in regional areas, and improve cultural responsiveness</p> <p>Increase access and places of rehabilitation, detoxification and psychiatric services, especially in regional communities, to ensure Aboriginal people do not have to travel off country to access treatment. Further, improve cultural responsiveness and remove barriers to access, with particular support for parents who require treatment for psychoactive substance use disorders</p>	DHHS and Victorian Government	<ul style="list-style-type: none"> <li>- Reduce waiting times</li> <li>- Reduce travel times</li> <li>- Reduce barriers to seeking help</li> <li>- Eliminate need to travel off-country to access critical services</li> </ul>	2015 –
<p>Increase focus of rehabilitation and detoxification services working with Aboriginal client families and carers</p> <p>Families and carers should have a central role in the treatment of people with psychoactive substance use problems wherever possible</p>	DHHS, Treatment services	<ul style="list-style-type: none"> <li>- Improve cultural responsiveness</li> <li>- Reduce psychological distress of clients and their families and/or carers</li> </ul>	2015 –

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## Appendix

### Appendix A – AMHFA course flyer

# Aboriginal Mental Health **First Aid** Community workshops

**Do you know someone experiencing  
a mental health problem?  
Do you want to know how to help?**

**VACCHO is running 10 FREE  
community workshops  
across Victoria.**

This workshop will give you the knowledge to understand the following about mental health and alcohol and other drug-related problems:

- Recognise the signs and symptoms
- Understand the possible causes or risk factors
- Be aware of all treatments available
- Take appropriate action if a crisis arises

*all  
participants  
who complete this  
course will receive  
a certificate of  
completion*

**Spaces are limited**

**Eastern Metro 22-24 July 2014**

**Bendigo 29-31 July 2014**

**Lake Tyers 12-14 August 2014**

**Portland 12-14 August 2014**



**VACCHO**

For more **information** or to **register**, please contact Angelina Kastamonitis on 03 9411 9411 or [angelinak@vaccho.com.au](mailto:angelinak@vaccho.com.au)



VACCHO acknowledges  
the support of the  
Victorian Government



# Aboriginal Mental Health First Aid Community workshops Enrolment form

## Workshop selection

Please tick which of the below workshops will be your first and second preference to attend.

Dates	Location	1st preference	2nd
22 - 24 July 2014	Eastern Metro	<input type="checkbox"/>	<input type="checkbox"/>
29 - 31 July 2014	Bendigo	<input type="checkbox"/>	<input type="checkbox"/>
12 - 14 August 2014	Lake Tyers	<input type="checkbox"/>	<input type="checkbox"/>
12 - 14 August 2014	Portland	<input type="checkbox"/>	<input type="checkbox"/>

## Personal details

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Contact number: \_\_\_\_\_

Email \_\_\_\_\_

Preferred way of contact:

Mail

Phone

Email

## Indigenous status

Aboriginal

Torres Strait Islander


Aboriginal & Torres Strait Islander

Non-Aboriginal

Signature \_\_\_\_\_

Date \_\_\_\_\_





VACCHO

# Need \$3500 to become an Aboriginal Mental Health First Aid Course Instructor?

Scholarship  
Expression of interest

**Send your Expression of Interest now**

**Final applications due 28 April 2014**

The Victorian Aboriginal Community Controlled Health Organisation (VACCHO) has been funded by the Victorian Government Department of Health to offer a limited number of scholarships to help Aboriginal and Torres Strait Islander people become an Aboriginal Mental Health First Aid Course Instructor.

**What is Mental Health First Aid?**

Mental health first aid is the help provided to a person developing a mental illness or in a mental health crisis. The first aid is given until appropriate professional treatment is received or until the crisis resolves.

**What does becoming an Instructor mean?**

The Aboriginal and Torres Strait Islander Mental Health First Aid Instructor Training (AMHFA) Course accredits you to conduct the 14-hour Aboriginal and Torres Strait Islander Mental Health First Aid course. Instructors can then deliver and charge for the course.

**When is the course?**

The five (5) day course will be held from 5 – 9 May, 2014 at The Vibe Hotel, Carlton in Melbourne. Instructors are provided with a complete teaching kit and ongoing support after the training.

Expressions of interest must be received by 5pm, 28 April 2014 to be considered.

**What does the scholarship include?**

Scholarships include:

- Instructor training course fee (\$3,500), tuition, catering, resources, membership

Scholarships **do not** include:

- Travel, accommodation and other incidentals associated with course attendance

**Who should apply?**

Aboriginal mental health and SEWB workers, health workers or counsellors employed by an ACCHO or non-Aboriginal organisation, as well as other people with mental health experience. You must be an Aboriginal and/or Torres Strait Islander person.

**Who do I send my Expression of Interest to?**

**Please email this expression of interest to  
Please email this expression of interest to  
chrish@vaccho.com.au ASAP.**

If eligible, you will receive further information and support to complete an application. Applications are due no later than 5pm 28 April 2014.



Victorian Aboriginal Community Controlled Health Organisation is the peak body for Aboriginal health in Victoria



VACCHO acknowledges the support of the Victorian Government

## Expression of Interest

**Contact name:** Title \_\_\_\_\_ First \_\_\_\_\_ Last \_\_\_\_\_

**Contact position title:** \_\_\_\_\_

**Contact:** Home phone \_\_\_\_\_ Mobile \_\_\_\_\_

Email \_\_\_\_\_

**Organisation name:** \_\_\_\_\_

**Address:** Street: \_\_\_\_\_ Town/Suburb: \_\_\_\_\_

Post code: \_\_\_\_\_ State: \_\_\_\_\_

**Contact:** Work phone \_\_\_\_\_

### Please answer the following questions

- I am an Aboriginal and/or Torres Strait Islander person
- I live in Victoria
- I have some knowledge of mental disorders and their treatment
- I have some personal or professional experience with people with mental health problems
- I am interested in learning more about mental health
- I am interested in teaching others
- My workplace and manager will support me
- I am able to conduct at least three training sessions (two days) a year

### Tell us why you would like to become an Aboriginal Mental Health First Aid Instructor?

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**Please email this expression of interest to [chrish@vaccho.com.au](mailto:chrish@vaccho.com.au) ASAP.**

**For questions, call or email Chris Halacas: 03 9411 9411 or [chrish@vaccho.com.au](mailto:chrish@vaccho.com.au)**

## Appendix C – Pharmacotherapy training flyer

Example of one pharmacotherapy training flyer. Flyers were adapted to each site.



# Pharmacotherapy training

## Become a prescriber for your Aboriginal patients

### 10% of people using pharmacotherapies in Victoria are Aboriginal

Networking Health Victoria (NHV) and the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) with support from the Victorian Government Department of Health are offering three pharmacotherapy workshops for General Practitioners and Nurse Practitioners. The training will focus on clinicians prescribing to Aboriginal patients and those working within Aboriginal Community Controlled Health Organisations.

**What does becoming a prescriber mean?**

The workshop will provide GPs and Nurse Practitioners with the skills and required accreditation to prescribe pharmacotherapy for opioid dependence to both Aboriginal and non-Aboriginal people within the Victorian regulatory framework.

**Who can attend?**

Training will accredit GPs and Nurse Practitioners to prescribe pharmacotherapy for opioid dependence. Pharmacists, Practice Managers, CEOs and AOD workers will also benefit.

**Training content and structure**

Training will cover:

- Problematic pharmaceutical opioid use
- Drugs, dependence & harm minimisation
- Treatment approaches
- Clinical assessment of patients using opioids
- Methadone maintenance, buprenorphine and buprenorphine/naloxone maintenance
- Legal issues – permits, regulations, clinical standards and take-away policies

The training consists of two parts:

1. An online learning module covering the principles of safe opioid prescribing (a link will be provided closer to the training date. Completion is a pre-requisite to attend the full day workshop)
2. A one day face-to-face skills based workshop on prescribing Methadone and Buprenorphine, with a focus on Aboriginal and Torres Strait Islander patients

**Bairnsdale**

St Mary's Parish Centre Hall  
23 Pyke Street, Bairnsdale  
Saturday 26 July 2014  
8.45am-4.30pm

**What is the cost?**

There is no cost attached to this training. Subsidies available (GPs only) for travel over 100km.


**Continuing Professional Development points**

40 RACGP QI & CPD points will apply. ACRRM points will be applied for.


**How do I register?**

Please direct any registrations or queries to Toni Lamarche at Networking Health Victoria: [t.lamarche@nhv.org.au](mailto:t.lamarche@nhv.org.au) or call 9341 5268.

**"I used to think that people with drug issues were difficult and bad people but now I see how drug dependence can control people's lives and I am more understanding to people's situations. We have community members whose lives are well managed on pharmacotherapy, one person returned to fulltime work. It can take people a few tries to manage their drug dependence well and different people need different support."** - Janice Huggers, Practice Manager: Dhauwurd-Wurrung Elderly and Community Health Service



VACCHO  
Victorian Aboriginal Community Controlled Health Organisation is the peak body for Aboriginal health in Victoria



VACCHO acknowledges the support of the Victorian Government



## Register a workshop for your local region

VACCHO has been funded by the Victorian Government Department of Health to support member organisations hold 10 alcohol and other drug workshops. The workshops aim to bring local community members together to focus on ways to improve the health of Aboriginal people using alcohol and other drugs, including 'Ice'.

### What is the problem?

Alcohol and other drugs form part of the behaviours of many societies and communities, however there can be health consequences associated with addiction and misuse:

- 14% of people using needles and syringes in Victoria are Aboriginal.
- Liver cancer is higher among Victorian Aboriginal people.
- 1,500 people in Victoria registered for pharmacotherapy (methadone).
- Hepatitis C is 6-7 times higher among Victorian Aboriginal people, mainly through injecting drug use.
- 441 Aboriginal people are imprisoned, many due to alcohol and drug related crimes.

### What topics will be covered?

Topics will be adapted to local priorities (select topics of interest in the EOI form below). The general format is a morning information session with brief presentations on locally important topics, lunch, and a facilitated afternoon session creating a plan to build on current partnerships and share responsibility across local community organisations.

The outcome of each workshop will be used to inform immediate and future responses at the local and State level.

### How will we be covered for costs?

Each participating ACCHO will receive \$5,000 to cover catering, venue hire, and administrative costs of local staff.

### Who should come?

The morning information session would be open to community members. Suggested participants for the afternoon planning and action session include key staff members from ACCHOs (e.g. Practice Manager, CEO, AOD workforce managers), hospitals, mental health services (e.g. headspace, area mental health service), alcohol and drug services, job networks, Victoria Police, and community leaders. Invitations will be informed by each participating ACCHO.

### When will the workshops be held?

The 4-5 hour workshops must be held between May - August 2014.

### Please email this expression of interest to [chrish@vaccho.com.au](mailto:chrish@vaccho.com.au)

If you have any questions, contact Chris Halacas, Acting Senior Project Officer, on 03 9411 9411 or [chrish@vaccho.com.au](mailto:chrish@vaccho.com.au)



Victorian Aboriginal Community Controlled Health Organisation is the peak body for Aboriginal health in Victoria



VACCHO acknowledges the support of the Victorian Government

## Expression of Interest

**ACCHO name:** \_\_\_\_\_

**Contact name:** Title \_\_\_\_\_ First \_\_\_\_\_ Last \_\_\_\_\_

**Contact position title:** \_\_\_\_\_

**Contact:** Work phone \_\_\_\_\_ Mobile \_\_\_\_\_

Email \_\_\_\_\_

**Approved by the CEO?** Yes  No  If no, please explain ACCHO support.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please indicate topics you are interested in**

(note: these are not final):

Become a methadone prescriber

Become a methadone dispenser

Establish a needle and syringe program (NSP)

Establish a syringe dispensing unit

Develop/implement harm reduction policies

Latest innovations

Improve/develop local partnerships with NSPs

Improve/develop local AOD partnerships

Brief intervention

Cognitive Behavioural Therapy (CBT)

Alcohol and Cannabis

Methamphetamines

Other (please list):

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

**Please indicate what audience format would work best for your community for both sessions**

*Info session*

Open to all community members

Restricted to key local stakeholders, service providers, decision makers, community leaders only

Other (please describe):

\_\_\_\_\_  
\_\_\_\_\_

*Planning and action session*

Open to all community members

Restricted to key local stakeholders, service providers, decision makers, community leaders only

Other (please describe):

\_\_\_\_\_  
\_\_\_\_\_



**VACCHO**  
VICTORIAN ABORIGINAL COMMUNITY  
CONTROLLED HEALTH ORGANISATION

**Caring for our mob:**  
**Reducing health related harms of alcohol and other drugs**

**Facilitator Brief**

**What we seek**

An experienced facilitator for nine workshops on reducing alcohol and other drug harms among Aboriginal communities.

**Requirements**

The 4-5 hour workshops will be held across Victoria between June and September 2014.

The facilitator will support VACCHO to provide information on reducing harms associated with alcohol and other drug use and develop a local action plan.

Audiences will include Aboriginal community members and local key stakeholders in health and community services.

**Outputs**

The facilitator will support VACCHO collect information to identify:

- Local priorities
- Key themes and hotspots across Victoria
- An action plan, with input from the ACCHO and key stakeholders at each workshop

VACCHO is responsible for logistics and reporting.

**Organisation background**

The Victorian Aboriginal Community Controlled Health Organisation (VACCHO) was established in 1996 as the peak representative Aboriginal health body in Victoria. VACCHO's work is driven by the priorities of our members, Victoria's Aboriginal Community Controlled Health Organisations (ACCHOs) located across the state and just over the border into New South Wales. By joining together under VACCHO's umbrella, ACCHOs gain strength, share knowledge and speak with a united voice.

VACCHO champions community control and health equality for Aboriginal communities. We are a centre of expertise, policy advice, training, innovation and leadership in Aboriginal health. VACCHO advocates for the health equality and optimum health of all Aboriginal people in Victoria.

## **Project background**

Aboriginal people in Victoria experience a significant overrepresentation in harms associated with alcohol and other drug use, including:

- 14% of people using needles and syringes in Victoria are Aboriginal
- Liver cancer is higher among Victorian Aboriginal people
- Approximately 10% of pharmacotherapy patients in Victoria are Aboriginal
- Hepatitis C is 6-7 times higher among Victorian Aboriginal people, mainly through injecting drug use
- 441 Aboriginal people are imprisoned, many due to alcohol and drug related crimes

VACCHO was funded by the Victorian Government Department of Health in April 2014 to hold nine workshops to address some of these harms in Aboriginal communities. The workshops aim to provide information on reducing harms associated with alcohol and other drugs as well as develop a local action plan.

An Expression of Interest (EOI) has been received from nine ACCHOs. Each EOI includes a list of topics to be discussed at the workshop (see attached for a summary of topics). Each workshop is expected to last approximately 4 – 5 hours, broken into two sessions:

- Morning – Information session with evidence-based presentations on topics selected by the ACCHO
- Afternoon – Develop an action plan, focusing on building partnerships and sharing responsibility across local community organisations

## **Objective**

The aim of these workshops is to present locally relevant evidence-based information on alcohol and other drug-related harms and models to address these.

In addition to this information, VACCHO seeks to identify:

- Local priorities
- Key themes and hotspots across Victoria
- An action plan, with input from the ACCHO and key stakeholders at each workshop

## **Target audience (be specific)**

Audience members are likely to include a mixture of the following:

- ACCHO staff members
- Local Aboriginal community members
- AOD service providers
- Mental health service providers
- Hospitals
- Community health services
- Police
- Employment agencies

Each ACCHO was asked to identify who they would like to attend both the morning (information) session and afternoon (planning and action) session. Most ACCHOs requested the morning session to be open to all Aboriginal community members and stakeholders, with a more even split in the afternoon.

## **Key messages**

- Health-related harms of alcohol and drug use can be reduced
- Emphasise the harm of zero tolerance approaches to alcohol and other drugs
- Support for harm reduction services, including NSPs
- Partnerships between local service providers and ACCHOs are imperative to reducing health-related harms

## Dates and locations

All workshops must be held by early September 2014. Final dates are still being negotiated. Sites are listed below.

### *Confirmed date*

1. Wednesday, 11 June in Horsham (Goolum Goolum Aboriginal Co-operative) – No facilitation required
2. Wednesday, 18 June – Shepparton/Mooroopna (Rumbalara Aboriginal Co-operative)
3. Thursday, 17 July – Robinvale (Mallee District Aboriginal Services)
4. Tuesday, 22 July – Warrnambool (Gunditjmara Aboriginal Co-operative)
5. Tuesday, 29 July – Ballarat (Ballarat and District Aboriginal Cooperative)
6. Thursday, 14 August – Bairnsdale (Gippsland and East Gippsland Aboriginal Co-operative)

### *Date to be confirmed (likely August-early September 2014)*

7. Albury/Wodonga (AWAHS/Mungabareena)
8. Geelong (Wathaurong)
9. Morwell/Sale (GEGAC Morwell and Ramahyuck)

## Budget

VACCHO will compensate for the facilitator's time, accommodation, and travel costs.

## VACCHO contacts

The main VACCHO contacts for this project include:

- Ms Louise Lyons ([louisel@vaccho.com.au](mailto:louisel@vaccho.com.au)) – Manager, Public Health & Research Unit
- Mr Chris Halacas ([chrish@vaccho.com.au](mailto:chrish@vaccho.com.au)) – Senior Project Officer
- Mr Kulan Barney ([kulanb@vaccho.com.au](mailto:kulanb@vaccho.com.au)) – Project Support Officer

VACCHO's switchboard number is (03) 9411 9411.



## Appendix F – Standard Harm Reduction Workshop Flyer

Example of one harm reduction workshop flyer. Flyers were adapted to each site and audience (i.e. community and stakeholder).

# Caring for our mob



**Community workshop**

## Are alcohol and other drugs affecting our community's health and wellbeing?

**We welcome you to our harm reduction workshop bringing together local community members and key stakeholders in health and community services.**

**This is an opportunity to:**

- Learn to reduce health risks of alcohol and other drugs
- Exchange information
- Develop a local harm reduction action plan

**Your input will also help us improve the health of our community.**

### Did you know:

- 14% of people using needles and syringes in Victoria are Aboriginal
- Liver cancer is higher among Victorian Aboriginal people
- 1,500 Aboriginal people in Victoria registered for pharmacotherapy (methadone)
- Hepatitis C is 6-7 times higher among Victorian Aboriginal people, mainly through injecting drug use
- 441 Aboriginal people are imprisoned, many due to alcohol and drug related crimes

## Workshops and lunch is free

**Come and learn how to reduce the health risks of alcohol and other drugs in our Community and lets come up with a plan to address the problem.**

**Date:**  
**Time:**  
**Venue:**

**RSVP:**



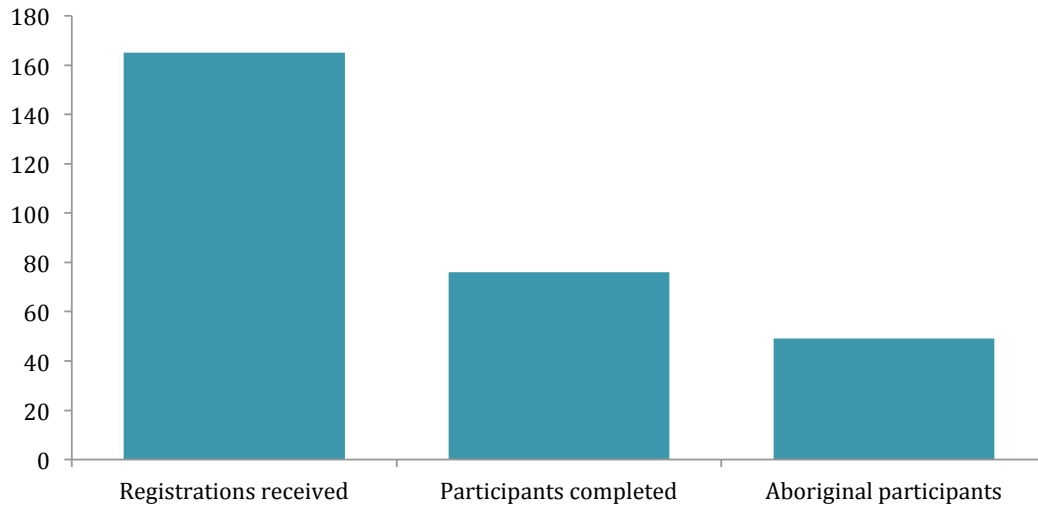
**VACCHO** Victorian Aboriginal Community Controlled Health Organisation is the peak body for Aboriginal health in Victoria



VACCHO acknowledges the support of the Victorian Government

**Appendix G – AMHFA Community Workshops**

**Aboriginal Mental Health First Aid**



**Age breakdown**

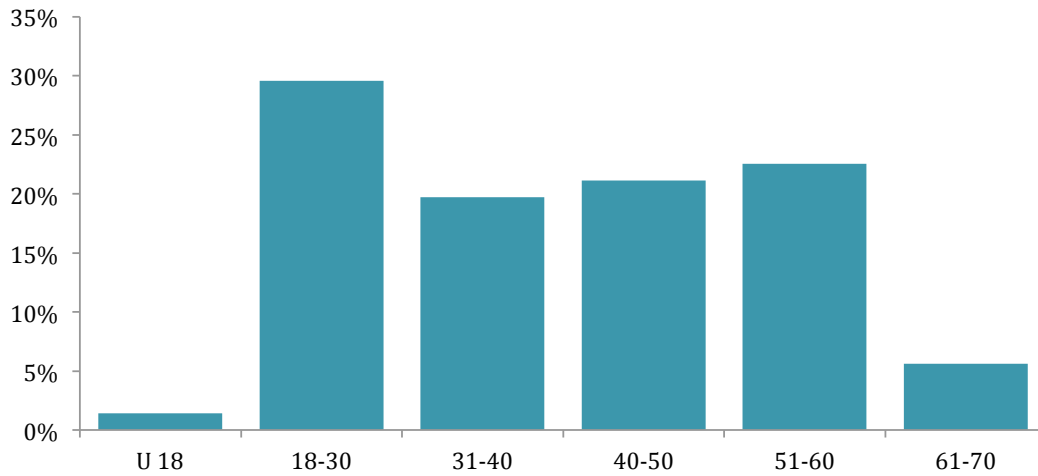
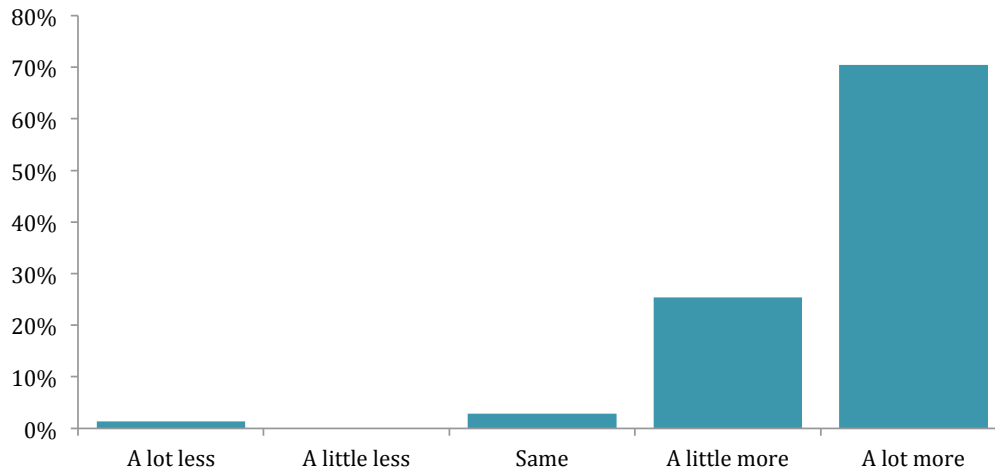


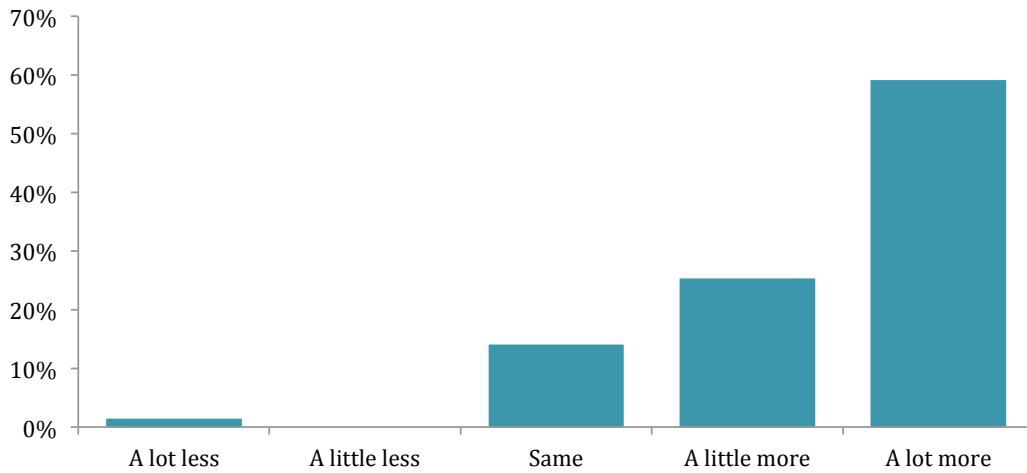
Chart: Post-workshop key word analysis of motivation to attend



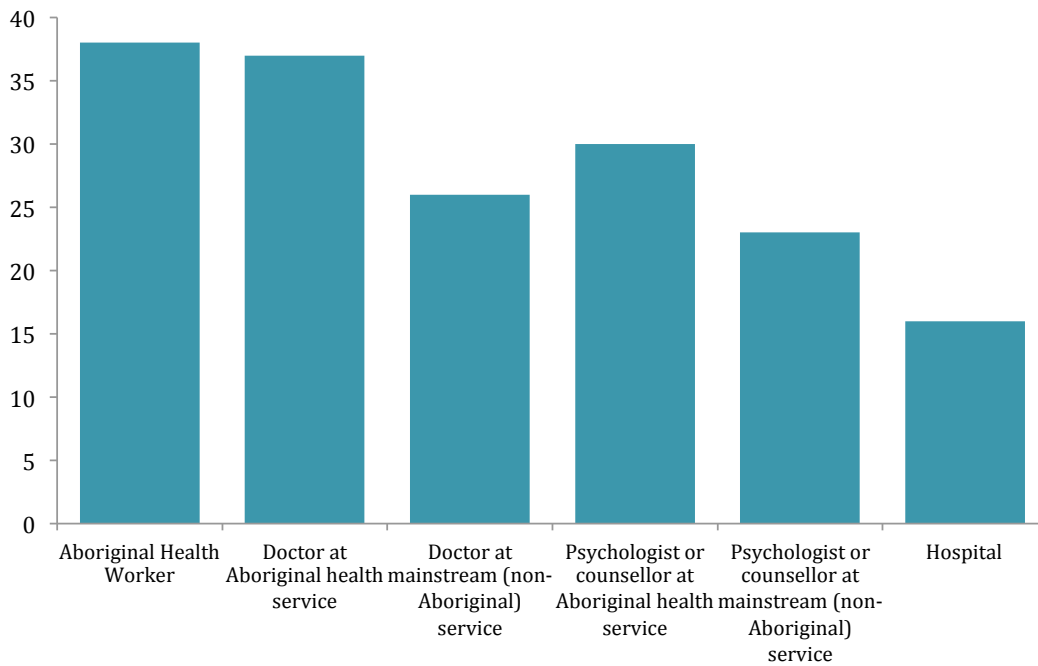
### I know how to get help for myself or someone else

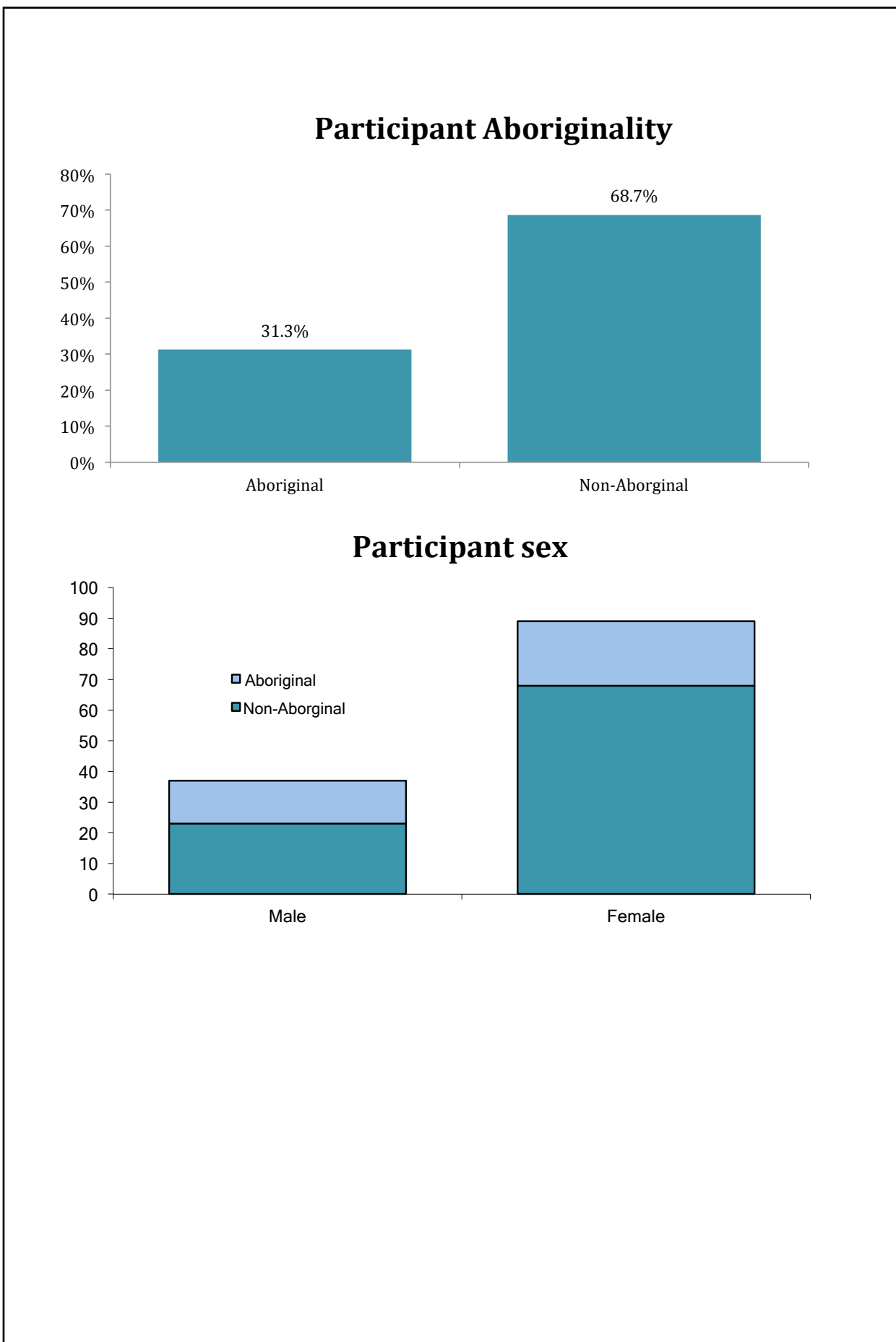


## I would use a mental health service if I needed to

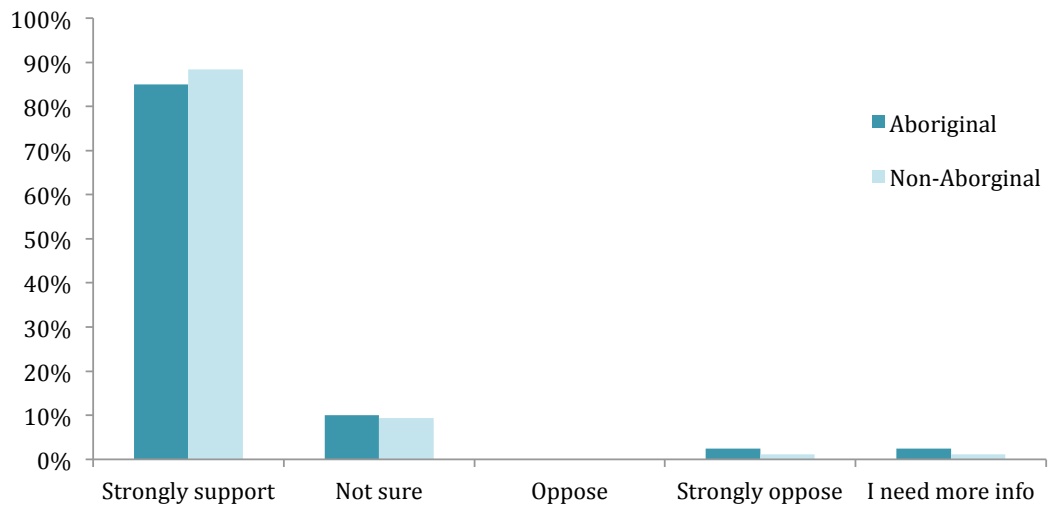


## I would prefer to seek help with

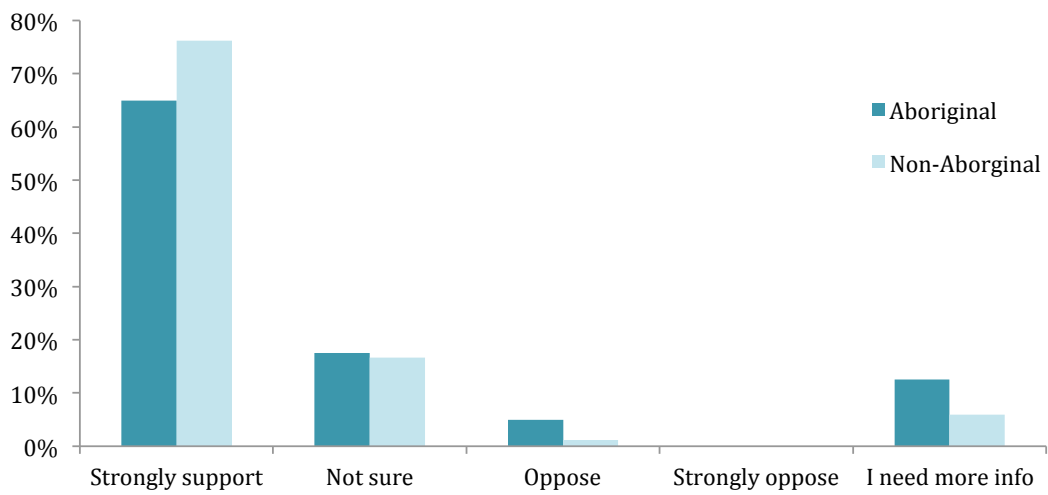




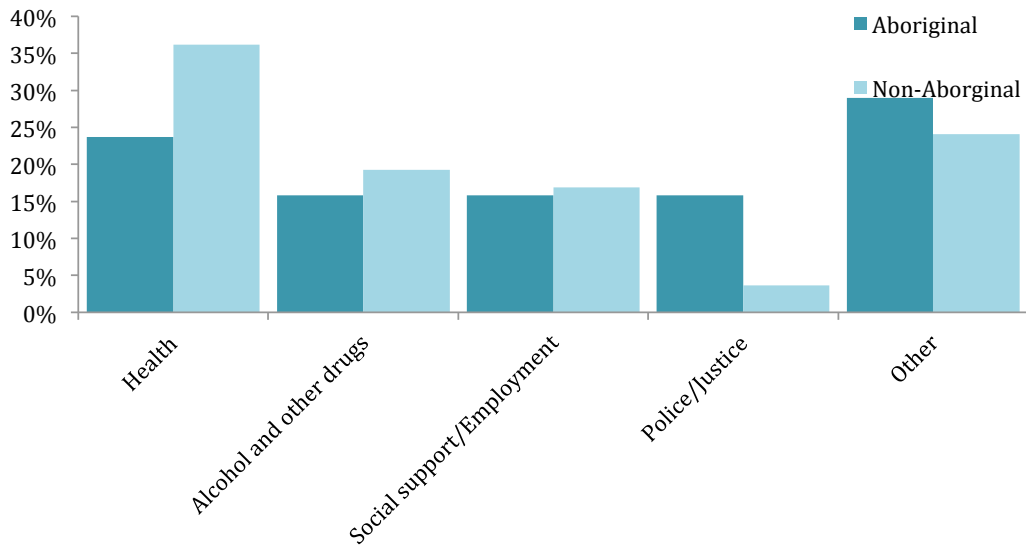
### Do you support or oppose needle syringe exchanges in your community?



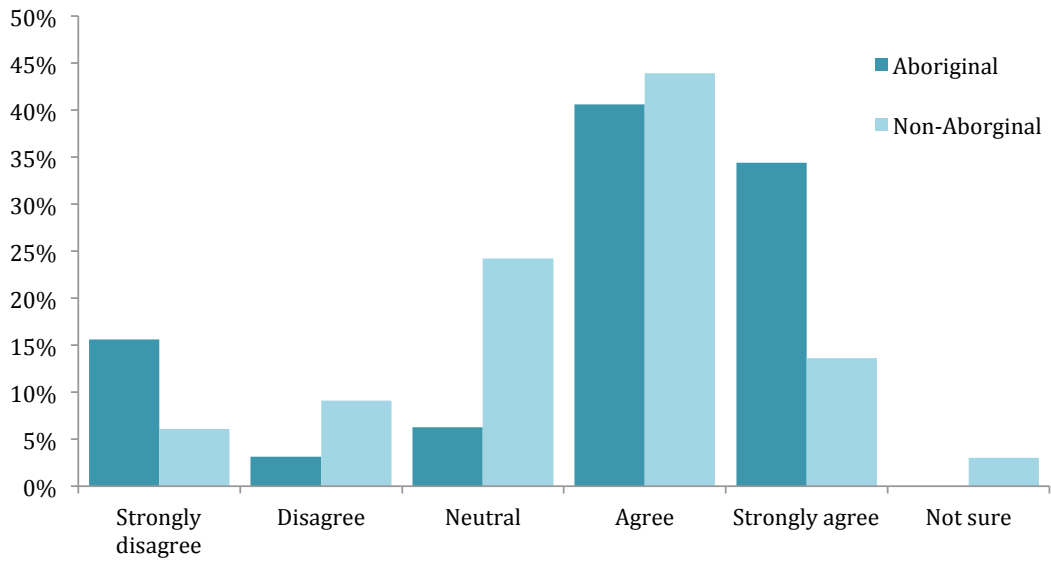
### Do you support or oppose the methadone maintenance program in your community?



## Sector of employment - local services



## We work well with the Aboriginal community





"Not everyone has that support"  
An evaluation of a series of harm reduction and AOD awareness activities  
within Victorian Aboriginal communities